Improving care for older people

A policy for Health Services

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Improving care for older people: a policy for Health Services

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Foreword from the Ministers

Most older people are independent and active. However, for some people, ageing brings frailty and chronic illness. Older people are significant users of Health Services and, in the coming years, population growth combined with ageing will mean that a greater number of older Australians will need access to health and community care services.

There is a strong correlation between older age and demand for medical and hospital services. Currently, people over the age of 70 years use 46 per cent of multiday patient stays in public hospitals. This represents a new challenge for Victorian Health Services and is likely to continue.

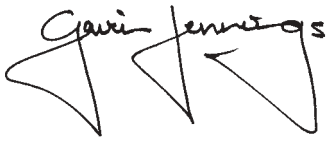
The Victorian Government, together with Health Services, has a clear responsibility for meeting the health care needs of the increasing number of older people. To address this challenge, we will need to fundamentally change the way we care for older people and alter our processes so that we can be more responsive to their needs.

Older people in hospitals often have a number of different diagnoses and consequently have multiple and complex needs. Compared to younger age groups, a greater proportion of older people require an interdisciplinary approach to their care to deal with complex co-morbidities, social and psychological issues. Health care professionals need to ensure that they have specific knowledge about care requirements of older people and the right tools and skills to appropriately manage their care.

People are staying in hospital for shorter periods due to advances in medical treatment and increased opportunities for community-based care. One major challenge for Health Services is to coordinate and integrate care to provide a comprehensive service across care settings. Another challenge will be to effectively manage the interfaces both within a Health Service's community-based programs and between Health Services and the range of ongoing support services available in the broader community.

This paper addresses these issues by identifying the key principles underpinning the effective care of older people and providing direction for Health Services in developing improved practices and processes. Building on these principles will ensure that older people receive appropriate treatment and care in the appropriate settings.

The Victorian Government is committed to ensuring that the principles identified here are implemented. We encourage you to embrace this policy document which presents a practical vision for improved health and community care services for older Victorians.



Gavin Jennings MLC
Minister for Aged Care

Hon Bronwyn Pike MP
Minister for Health

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Preface–towards better care for older Victorians

This paper communicates the broad policy direction for improving and integrating the care of older people accessing Victorian Health Services. It focuses on the use of common processes that can improve the quality and continuity of care delivered through the health system.

This paper is the first in a number of policy papers that address the treatment and care of people with complex and chronic conditions who would benefit from enhanced continuity of care.

While older people (aged 70 years and over) are the focus of this policy, improvements to the service systems outlined here will also improve the quality of care provided for other groups with complex and chronic conditions.

Health Services, as referred to in this policy, include the acute and sub-acute campuses of a Health Service, as well as the additional programs that a Health Service provides in the community. The term 'Health Services' has been capitalised to differentiate it from general health care and ongoing community support services delivered by various providers in the community.

The department has produced this policy to encourage Health Services to:

(1) adopt a strong, person-centred approach to the provision of care and services

(2) better understand the complexity of older people's health care needs

(3) improve integration within Health Service's community-based programs and between Health Services and ongoing support services available in the broader community.

The health system can provide quality care for people with complex needs by building better integrated services with clear referral criteria, using the expertise in the specialist hospital system and drawing on the support of the community care system.

This paper builds on previous work of the Victorian Department of Human Services, including the *Rehabilitation into the 21st Century report* (Department of Human Services, 1997) which presented a vision for integrated delivery of rehabilitation services.

Sub-acute services strategic directions Victoria (Sach, J. and Associates, 2001) has also been influential. It provided a strategic vision and context for policy development in state and regional service provision. In particular, it identified how sub-acute services could function more effectively within an integrated health system model.

Other significant pieces of departmental work that have informed this policy include: *Victoria's Mental Health Service: the framework for service delivery – aged persons services* (Department of Human Services, 1996); *New directions for Victoria's mental health services* (Department of Human Services, 2002a); *Victorian State Disability Plan 2002–2012* (Department of Human Services, 2002b); the output of the Patient Management Task Force; the *Effective Discharge Strategy*; and the working party

report *HARP–integrated care for clients with complex needs* (Department of Human Services, 2003a).

The work of the Acute to Sub-acute Breakthrough Collaborative has been invaluable to the development of this policy. This collaborative has brought all of the larger Victorian sub-acute services to work together during 2002–03 to improve access, quality and safety in patient care.

The department has also drawn on the work of the Clinical Epidemiology and Health Service Evaluation Unit at Melbourne Health, with particular reference to their paper entitled *Evidence based guidelines: prevention of functional decline in elderly patients* (Royal Melbourne Hospital, 2002).

The department's Aged Care Branch, including the Home and Community Care (HACC) program, contributed to this paper in relation to the impact that it may have on the department's policies and programs relating to aged care and HACC services.

The important work of the Victorian Office of Multicultural Affairs in highlighting the issues of relevance to people from culturally and linguistically diverse backgrounds is also acknowledged, especially in relation to the provision of culturally appropriate health care services.

This paper attempts to synthesise and put into operation the findings from the important pieces of work mentioned above. It also informs the broader work of the department in improving and integrating the care of older people accessing Victorian Health Services.

Acknowledgements

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Executive summary

Improving care for older people: a policy for Health Services highlights the need to change health care practices in response to the shifting demographic of the Victorian population. Older people are significant users of health services. People over the age of 70 years use more than 46 per cent of all multiday patient stays. As our society ages, all Health Services will experience a rise in the percentage of older people requiring treatment and care.

Health Services will need to implement plans, policies and procedures that ensure the quality of care provided to older people is in keeping with practice based on best evidence.

This paper focuses on improving the care provided for older people by Health Services and integrating care across settings to ensure that people have the appropriate care in the appropriate place. Three fundamental issues have emerged in considering how to improve and integrate the care of older people, namely the need to:

1) adopt a strong person-centred approach to the provision of care and services
2) better understand the complexity of older people's health care needs
3) improve integration within Health Service's community-based programs and between Health Services and ongoing support services available in the broader community.

Specific care issues for older people

The age related functional decline of physiologic systems means that older people are less able to prevent and recover from illness and are more susceptible to deconditioning. Functional decline has been identified as a leading complication of hospitalisation of older people and can manifest as the development of malnutrition, decreased functional mobility, loss of skin integrity, incontinence, falls, the development of delirium, problems with medication, poor self-care and depression. There is also evidence that functional decline in older people is associated with adverse outcomes ranging from increased length of stay to higher levels of institutionalisation and increased mortality.

In responding to the specific care issues of older people, it is essential that Health Services are aware of and apply practice based on best evidence. Through this, older people will experience a reduction in functional decline and adverse events while receiving care from the Health Service.

Improving care: principles and processes

The principles and processes for improving the care of older people have been identified. These include the expectation that Health Services will have a clinical governance responsibility to provide care that reduces the risk of adverse events for older people and supports them to maintain or reach their optimal level of independent functioning.

One of the major principles identified in this paper is the importance of involving older people in their own care. Through doing this, Health Services can better recognise and address issues that are central to the person's recovery. If older people and where appropriate, their carers, are involved in planning care and treatment, then Health Services can more quickly identify the issues that may prevent or delay the person's return home.

Older people often have complex care needs and may have co-morbidities that require a holistic, problem-solving approach to their care. To achieve this, it is important that older people are risk screened upon contact with the Health Service and, if the risk screen is positive, that they receive a comprehensive assessment. Risk screening using validated tools can be carried out by a variety of professional disciplines.

The older person's care plan should be built on information gathered from the comprehensive assessment. Care planning should be person-centred and interdisciplinary in approach. This means that the goals of the older person, and their carers where appropriate, should be used as the focus of the care plan. An interdisciplinary approach requires that the team of health care professionals work together to plan for care that meets the older person's central goals. It is also important that older people are included in planning for their transition back to the community and that they have their care coordinated through a single person.

The presence of a carer is often the significant factor in enabling an older person to return to, or remain living in, the community. However, caring also has consequences for the people supporting the older person, and health care professionals need to be aware of the stress and difficulties that affect carers when planning the transition from the hospital setting.

The care of people who move across different levels of the health system should be coordinated and appropriate information shared, to avoid delays and provide a smooth continuum of care. Care coordination should be based on the person's needs as outlined in the care plan.

Integrating care: principles and processes

Treatment, therapy and care for older people can be provided in many settings. The boundary between hospital and community care has changed over the last decade with a number of conditions now safely managed in the community. In moving from one care setting to another, it is important that the care is provided in an integrated way that meets the person's and carers' needs. Care settings should be designed and managed so that appropriate physical, social and environmental features relating to the special needs of older people are provided.

Interface between Health Services and ongoing community support providers

To resume living independently in the community, many older people need ongoing community support services. The interface between Health Services and ongoing community support providers is an important one. Both need to actively work together to ensure that older people experience an integrated and effective transition from the Health Service's care settings to the broader community.

Health Services require strong and robust protocols and agreements with ongoing community support providers. This will ensure that treatment and care provided by Health Services are used for time-limited responses only. By taking an integrated approach, Health Services, together with ongoing community support providers, can manage many of the chronic conditions and diseases that affect older people. This will result in better outcomes and continuity of care for older people.

Significant numbers of older people often remain in hospital after they have completed their episode of acute or sub-acute care while they are waiting for a residential care place to become available (Department of Human Services, 2002c). The care provided in acute and sub-acute inpatient settings may not be the most appropriate for this group of people, and short-term alternatives to this have been developed.

Promoting independence in the community

Older people, and people who have multiple and complex needs, often require access to specialist assessment and treatment and a variety of support services to be able to maintain their independence in the community. Health Services provide a number of programs that support the independence of older people, including inpatient services, centre-based and home-based rehabilitation, and specialist assessment and management.

People of all ages who need sub-acute care and access to specialist diagnostic and therapeutic services as well as rehabilitation services should be able to more easily access these services through the development of Centres Promoting Health Independence. The centres will be promoted as a resource that enables all people (with a focus on older people) to maintain their optimal independence in the community. Centres Promoting Health Independence will be expected to work collaboratively with all Health Services in their region to support the delivery of quality services.

Principles for the care of older people in Victorian Health Services

The following principles underpin the policy outlined in this paper. These principles form the basis of practices and processes that address the fundamental issues for Victorian Health Services in providing care for older people. Key objectives have been developed to indicate practical ways in which each principle is to be implemented.

Specific care issues for older people

Principle 1:

Health Services apply practice based on best evidence to the care of older people, including specific attention to the risk of malnutrition, decreased functional mobility, loss of skin integrity, incontinence, falls, the development of delirium, problems with medication, poor self-care and depression.

Key objective

1.1 That older people under the care of Health Services receive care that is based on best evidence.

Clinical governance responsibility

Principle 2:

Health Services take clinical governance responsibility for the care of older people.

Key objective

2.1 That Health Services give specific attention to clinical effectiveness, risk management, education and training, and consumer participation in the care of older people.

Involving older people and carers

Principle 3:

Treatment and care provided by Health Services places the person at the centre of their own care and considers the needs of the older person's carers.

Key objectives

3.1 That older people and, where appropriate, their carers, are actively engaged in care planning processes.

3.2 That older people and their carers are given the opportunity to provide feedback that is used for quality improvement purposes.

Identifying people with additional care needs

Principle 4:
Health Services identify older people at risk of adverse health outcomes and/or having existing or potential supportive care requirements.

Key objective

4.1 That Health Services screen older people for the risk of adverse health outcomes or having existing or potential supportive care requirements.

Assessing care needs

Principle 5:
Treatment and care provided for older people with a positive risk screen includes the completion of a comprehensive assessment.

Key objectives

5.1 That every person over 70 years of age who is identified by the screen as at risk of adverse health outcomes and/or having existing or potential supportive care requirements has a comprehensive assessment, including identification of carer needs.

5.2 That Health Services take an interdisciplinary approach in assessing the care of older people.

Planning care

Principle 6:
Treatment and care provided for older people includes interdisciplinary care planning that is founded on evidence-based care pathways.

Key objectives

6.1 That Health Services use evidence-based care pathways for major clinical conditions.

6.2 That a coordinated care plan is developed for all people whose risk screen has identified existing or potential supportive care requirements and transition issues.

6.3 That older people who have undergone a comprehensive assessment will have an interdisciplinary care plan developed. This care plan will be based on the person's and, where appropriate, their carer's goals and bridge the person's transition from hospital to the community.

6.4 That older people participate in their care planning as part of an interdisciplinary team. The person's general practitioner, existing ongoing community support provider and carers are included in the interdisciplinary team.

6.5 That care planning includes discussion with the older person and their carers regarding their future care and palliation wishes.

Transition planning and coordination of care

Principle 7:

Treatment and care provided for older people is coordinated to achieve integrated care across all settings.

Key objectives

7.1 That people assessed as having complex care needs have a single person coordinate their care by working with them and their carers.

7.2 That care coordination for older people is provided in both the hospital and the community to facilitate the older person's return to their usual residence, with ongoing support as required.

Hospital inpatient care

Principle 8:

Older people receive treatment and care in the setting that best meets their needs and preferences where it is safe and cost effective to do so.

Key objectives

8.1 That older people receive appropriate care in the appropriate setting.

8.2 That the hospital setting provides appropriate physical, social and environmental features to meet the special needs of older people.

Health Service community-based programs

Principle 9:
Health Services integrate their community-based programs to provide the appropriate treatment, therapy and supportive care to meet the needs of older people.

Key objectives

9.1 That community rehabilitation centres accommodate an expanded role as providers of integrated sub-acute community-based services.

9.2 That community-based programs provided by Health Services are integrated to provide appropriate treatment, therapy and supportive care, with a single entry point and referral system.

Relationships between Health Services and ongoing community support services

Principle 10:
Robust protocols and agreements developed between Health Services and ongoing community support providers ensure that older people continue to receive the care they require in a coordinated and integrated manner.

Key objectives

10.1 That older people experience integrated care (and case management where required) through coordination between Health Services and ongoing community support providers.

10.2 That Health Services arrange supportive care services, where required, for a maximum of 28 days to enable the person to return home. (There may be exceptions and a degree of flexibility needs to be maintained to ensure that a person receives the level of care they require).

10.3 That post-discharge, ongoing community support providers continue to provide up to the level of service that the person received prior to their hospital episode. Health Services will facilitate this by notifying providers when a client of theirs has been admitted and indicating a likely discharge date.

10.4 That Health Services ensure their time-limited supportive care programs have similar processes and protocols to ongoing community support providers to enable the older person and their carer to move smoothly between providers.

10.5 That Health Services participate in the service coordination work of their local Primary Care Partnership.

Older people awaiting long-term care options

Principle 11:

An adequate level of support for people awaiting long-term care options is provided in the setting that best meets their needs.

Key objectives

11.1 That people who have been assessed in hospital as requiring residential aged care continue to receive appropriate care from Health Services.

11.2 That Health Services assist people and their families to obtain timely access to long-term care.

Promoting health independence

Principle 12:

All people across Victoria have access to Centres Promoting Health Independence.

Key objectives

12.1 That existing extended care centres and some major sub-acute facilities are refocused into Centres Promoting Health Independence, with at least one designated centre in each departmental region.

12.2 That Centres Promoting Health Independence:

- provide a significant sub-acute inpatient service, with the size dependent on the catchment population
- provide or facilitate access to a range of sub-acute community-based services to enable people living in regional and remote areas to access clinical expertise, including centre-based and home-based services, cognitive, dementia and memory services, continence clinics, falls and mobility clinics and mobile outreach services
- are a focus for the development of statewide specialist services that provide health care professionals with additional skill levels and access to a wider support network for the management of people with complex needs
- where possible, co-locate with Aged Care Assessment Service (ACAS), aged psychiatric and mental health services and community support programs (such as community aged care packages) to provide a recognisable facility that supports people, particularly older people, to remain in their community
- provide access to a hydrotherapy pool

- are a recognised point of access (from the community or from acute services) to services for the prevention, treatment and management of disabling conditions
- are outward-focused community resources that provide information, services and facilities to older people and people with a disability

This document forms the basis of future work that will be supported by the Department of Human Services and presents a practical vision of the direction in which Health Services should be heading in the treatment and care of older people.

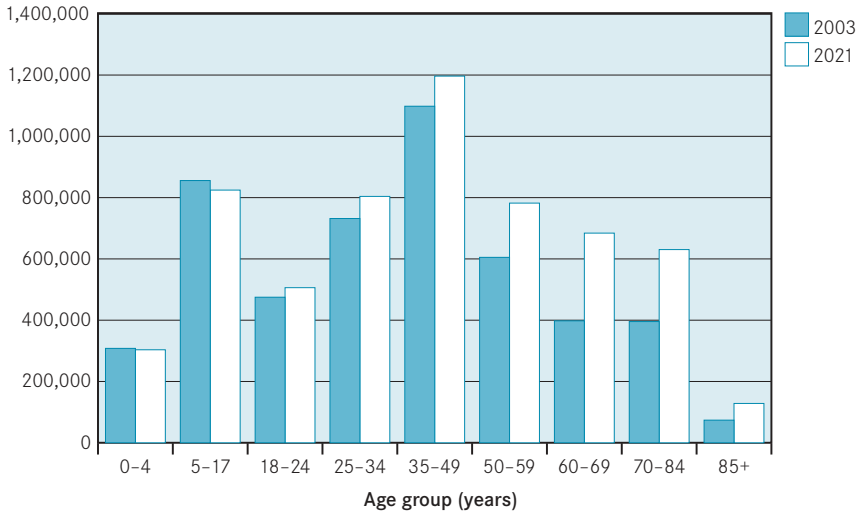
Introduction

Australia, like many western countries, has an ageing population. This is particularly true in the State of Victoria. The ageing population has many ramifications for the level of health care the population will require into the future, and for the way in which health and community care services are provided.

Department of Sustainability and Environment interim projections (2003) predict a 19 per cent growth in the total Victorian population by the year 2021. The rate of growth for the 70-84 years age group during this time-frame will be substantially higher and is expected to be in the order of 59 per cent.

Importantly, the 85 and over age group will experience an even larger percentage increase, growing by 74 per cent to 2021. Figure 1 shows an age grouped population structure now and into the future.

Figure 1: Victorian population structure projections 2003–2021



Source: Department of Sustainability and Environment, 2003

As people get older, changes to their physical condition mean that they use health services and community care services more frequently and for longer periods of time. For example, in 2000–01, people aged 70 years and over accounted for 27 per cent of all separations from Victorian public hospitals and 46 per cent of multiday patient stays. People over 85 years of age are 4.2 times more likely to be admitted to hospital than people aged 70–74 years (Department of Human Services, 2001–02a).

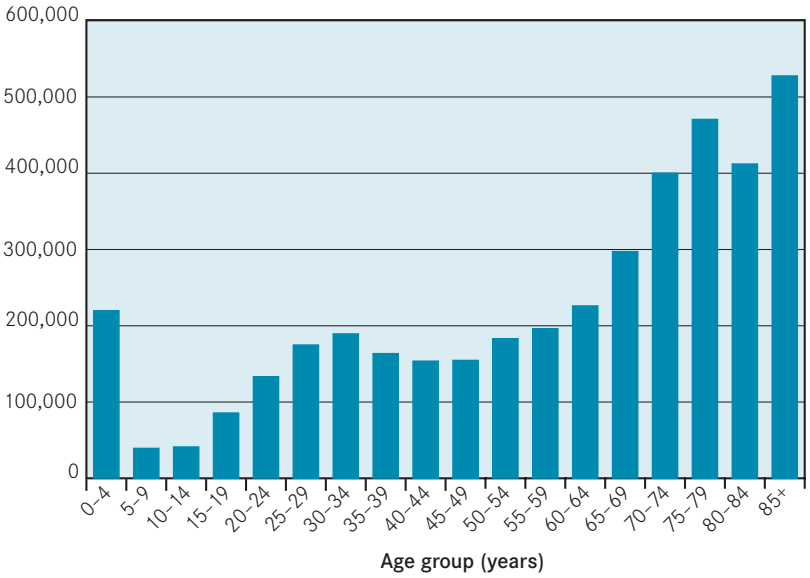
Older people are likely to have a number of co-morbidities resulting in complex care requirements. More than 63 per cent of people admitted to hospital over the age of 70 years have four or more diagnoses (Department of Human Services, 2001–02a). Older people also often need a longer time to recover from surgery and require more

from allied health and related services to prevent deterioration in function and increasing dependency while in the hospital setting.

Older people more often require multiday stays in the hospital environment and this increased use of hospital bed days is shown in Figure 2 below.

Figure 2: Public hospital bed days by age group 2001–02

(excluding unqualified newborns)



Source: Department of Human Services, 2001–02a

The older age group uses a disproportionate number of public hospital bed days and this trend has been steadily increasing. Public hospital multiday stays for people in the 70 years and over age group grew from 41 per cent to 46 per cent between 1995–96 and 2001–02, despite representing only 9 per cent of the population in 2001–02 (Department of Human Services, 2001–02a and 1995–96). It is, therefore, important that Health Services consider the needs of this patient group and provide appropriate responses.

Need for change

The number of older people in our community is increasing, and with age comes increased use of hospital services. The statistics above show that Health Services need to consider older people as their main client group and that health care professionals will need to develop expertise in the care of older people. Older people often have complex and chronic conditions; they require careful and comprehensive management.

Health Services need to ensure they identify the specific care issues that face this older population and instill a culture that places the person at the centre of their

own care. Working in a team with older people and their families provides the opportunity to practice holistic care and form rewarding relationships, for all those involved. The care of older people needs to be promoted as an exciting and innovative area, in which great gains can be made when treatment and care are integrated and coordinated.

Older people may require ongoing care

Older people often have an ongoing relationship with Health Services. Some require periodic treatment or therapy for chronic conditions or increasing frailty and may need additional supports to resume living in the community. Others, especially older people living alone, may frequently present to Health Services with a need for a high level of care and support but not the specialist treatment and level of care that an acute hospital provides. These patient groups require greater emphasis on care planning and coordination in order to navigate the transition back to the community and remain there safely.

Due to these ongoing requirements, many Health Services are now building relationships with ongoing community support providers to ensure that older people who can return home are supported to live independently. This approach prevents unnecessary hospital re-admission and improves quality of life for the older person. Strong relationships with ongoing community support providers will assist Health Services in achieving these goals.

Older people are the main users of Health Services and will continue to be so into the future. The delivery of treatment and care needs to be tailored to their individual requirements and include care planning and coordination. This should be provided in an appropriate environment and in a timely manner.

Principles and processes for care for older people

The principles articulated in this paper underpin the policy direction and form the basis of practices and processes that address the fundamental issues in providing care for older people.

In this paper, the discussion of each major principle identifies:

- key objectives (the ways in which the principle will be implemented)
- action areas for Health Services (possible change management issues for Health Services and health care workers)
- implementation issues (complex problems where the Department of Human Services will work with Health Services and staff to resolve these issues).

The paper also has distinct sections. Section one, *Specific issues for older people*, focuses on the key factors that place older people at risk of functional decline and adverse health outcomes during hospitalisation.

Section two, *Improving care: principles and processes*, examines the principles that underpin the care of older people. These include involving older people in their own

care and the processes required to deliver care and treatment–from the initial risk identification through to ongoing management of people with complex conditions.

Section three, *Integrating care: principles and processes*, discusses the importance of providing appropriate care settings for older people. This section also addresses the integration of care across settings and highlights the importance of relationship building between Health Services and ongoing community support providers.

Implementing the vision

The Government recognises that the changes involved in implementing the principles and processes articulated in this paper are significant and that their implementation will need to be incremental. It is acknowledged that these implementation issues will warrant further work and discussion.

Section one: Specific care issues for older people

This section focuses on the key factors that place older people at risk of functional decline and adverse health outcomes during hospitalisation.

Principle 1:

Health Services apply practice based on best evidence to the care of older people, including specific attention to the risk of malnutrition, decreased functional mobility, loss of skin integrity, incontinence, falls, the development of delirium, problems with medication, poor self-care and depression.

Older people are significant users of Health Services due to their often greater medical complexity and care requirements. Although much has been achieved over recent years to improve their care, older people often experience adverse events and poor outcomes following presentation or admission to Health Services.

It is essential that Health Services are aware of, and understand, the specific care issues for older people and how to manage these issues in accordance with practice based on best evidence. Older people will continue to access quality specialist services, but should have their treatment enhanced by an additional focus on meeting the specific care needs of this group.

The issue of functional decline

Functional decline is a decrease in physical and/or cognitive functioning. It is a leading complication of hospitalisation in older people and can occur as early as day two after being admitted as an inpatient. In addition, the age-related functional decline of physiologic systems means that older people are less able to prevent or recover from illness and are more susceptible to deconditioning (Royal Melbourne Hospital, 2002).

As cited in the Royal Melbourne Hospital's *Evidence based guidelines: prevention of functional decline in elderly patients*, between 34 and 50 per cent of older people experience functional decline in hospital, with as many as 30 per cent of people aged over 70 years returning home from a hospital stay with a reduced ability to perform the usual activities of daily living. This functional decline can manifest itself in the development of malnutrition, decreased functional mobility, loss of skin integrity, incontinence, falls, the development of delirium, problems with medication, poor self-care and depression.

There is also evidence that functional decline in older people is associated with increased length in hospital stay, higher levels of institutionalisation and increased mortality (Royal Melbourne Hospital, 2002).

Helping older people to maintain their functional status

Functional status and wellbeing are highly valued by older people and their carers, and should be essential outcomes of the care provided by Health Services.

Health Services need to pay particular attention to the key factors that place older people at risk of functional decline and other adverse events. Specific attention to

these factors can assist in restoring or maintaining older people's functional status and wellbeing, and enable them to retain their optimal level of independence and quality of life. These factors are discussed below.

Improving nutrition

Older people are particularly at risk of malnutrition. Malnutrition is a major health problem that contributes significantly to morbidity and mortality. It has also been linked to diminished cognitive and physical performance, and a reduced overall sense of physical and mental wellbeing.

Forty per cent of older people admitted to hospital are already malnourished and more than sixty per cent of older people have been found to be unable to maintain their nutritional status while in hospital (McWhirter and Pennington, 1994). This has been attributed to poor recognition and monitoring of nutritional status and inadequate intake of nutrients in the inpatient setting.

Malnutrition has been shown to increase the length of inpatient stay and appears to be a strong independent risk factor for non-elective hospital re-admission (Australian Society for Geriatric Medicine, 1997; Sullivan and Walls, 1994). Other documented adverse effects of malnutrition include increased risk of developing a pressure injury (Perneger et al., 1998), delirium (Inouye et al., 1996) and higher depression scores (Thomas et al., 2002).

Malnutrition may be the result of a swallowing disorder. Swallowing disorders can compromise an older person's health and wellbeing and may result in coughing, choking and chest infection, as well as malnutrition and dehydration. Studies have shown that swallowing disorders may affect up to 10 per cent of hospitalised older (Hudson et al., 2000).

Screening and early intervention are keys to the management of malnutrition in older people in both hospital and community settings.

Health Services need to ensure that older people receive adequate and appropriate nutrition and hydration during hospitalisation. While hospital meals are generally considered to be a 'hotel service', meals provided to older people in hospital are an important part of care.

Health Services should also be aware that meal scheduling, use of medications, swallowing and dental issues, and changes in environment may affect appetite and nutritional intake. For people with dementia, the risk of nutritional deficit may be heightened in hospitals when food is presented in unfamiliar circumstances or is not readily visible and recognisable.

Health Services need to ensure that an assessment that examines the older person's ability to maintain their own nutritional requirements is carried out and that it informs the older person's care plan.

Increasing functional mobility

The adverse effects of hospitalisation and bed rest present a significant problem for older people.

It has been found that almost one third of older people hospitalised for an acute illness experienced a reduction in their ability to perform activities of daily living (Sager et al., 1996). In addition, one in six older people became newly dependent in walking as a result of hospitalisation, with less than half of these people regaining their previous level of functioning three months after discharge from hospital (Mahoney et al., 1998).

Functional mobility programs have been shown to improve outcomes for older people by encouraging independence and activity. These programs may also help to reduce the length of hospital stay for patients, facilitate a quicker recovery and save money for Health Services (Dorevitch et al., 2002).

Hospitals should ensure they have sufficient nursing and allied health staff (including allied health assistants) to provide functional mobility programs to older people at risk of deconditioning in medical and surgical wards. Functional mobility programs should be incorporated into the older person's care plan, where appropriate.

Avoiding the loss of skin integrity

Older people have an increased risk of loss of skin integrity (which may be lead to skin tears and development of pressure injuries) following admission to hospital (Joanna Briggs Institute, 1997).

Loss of skin integrity can occur at any stage of a hospital stay and often begins in the emergency department. Pressure injuries are associated with increased hospital costs and longer length of stay (Allman et al., 1999).

It is important that people at risk of loss of skin integrity are identified early in their episode of care, preferably on admission, and that pressure injury risk is actively managed.

Health Services need to ensure that appropriate equipment and procedures are in place to reduce the loss of skin integrity in older people admitted to hospital.

Reducing incontinence

In Australia, incontinence affects over two million people, of which 70 per cent are women (Commonwealth Department of Health and Ageing, 2003).

Following a diagnosis of incontinence, the risk of hospitalisation is 30 per cent higher in women and 50 per cent higher in men. Further, the risk of entry into nursing homes is two times higher for incontinent women and three times higher for incontinent men (Continence Foundation of Australia, 2000). Incontinence may also contribute to falls in older people who are in hospital (Schnelle & Smith, 2001).

The use of an indwelling catheter (IDC) for managing incontinence is common in hospitalised older people, even though it is often inappropriate (Jain et al., 1995) and can be associated with the development of delirium, urinary tract infection, increased length of stay and increased mortality (Inouye et al. 1996; Riedinger et al., 1998; Palmer et al., 1994; Platt et al., 1982).

It is important to remember that a person's clinical/medical status, medication, mobility, physical environment (for example, access to toilet facilities,) and cognitive status can have an effect on their continence.

Older people need to receive appropriate assessment and interventions based on best evidence to prevent the onset of incontinence or to effectively manage existing continence issues.

Avoiding and reducing the incidence of falls

Falls and fall-related injuries remain a significant public health problem for people aged over 65 years in Australia.

Forty-five thousand people in this age group were hospitalised for fall-related injuries in 1998, averaging 11 days of hospital care for a total of 486,484 hospital bed days (Cripps and Jarman, 2001). In addition, falls are one of the most reported incidents in hospitals, with 38 per cent of all patient incidents in Australia involving a fall (Joanna Briggs Institute, 1998).

Estimated health care costs associated with falls among older Australians are more than $406 million annually (Mathers and Penm, 1999). If falls and fall-related injury rates continue at current levels, and the Australian population continues to age, the number of people presenting with falls and fall-related injuries is projected to escalate (Sanders et al., 1999).

The department has funded successful programs to prevent or reduce the incidence of falls in Victorian hospitals. Health Services should assess older people for their risk of falling and then use appropriate interventions.

It is recommended that Health Services ensure that all staff, patients and carers are aware of the increased risk to older people of falls in hospitals, by providing education and information. They should also assess patient management practices and physical environment to eliminate risks. For example, the use of high–low and low-low beds and other types of equipment reduces the incidence of falls. Health Services should also assess the risk of other contributors to falls among older people, such as medication.

Understanding delirium and dementia

Delirium and dementia are the most common causes of cognitive dysfunction. Although delirium and dementia may occur together, they are quite different. Delirium begins suddenly, causes fluctuations in mental function and is usually reversible. Dementia begins gradually, is slowly progressive, and is usually

irreversible. Both delirium and dementia may occur at any age but are much more common among older people, because of age-related changes in the brain (Beers & Berkow, 2003).

The two disorders affect mental function differently. Delirium impairs the ability to pay attention and to think clearly. Dementia causes loss of memory and a severe decline in all aspects of mental function (Beers & Berkow, 2003).

The prevalence of moderate to severe dementia among people aged 70–74 years is 11 per cent, rising to 18 per cent for people aged 75–79 years and 40 per cent for people aged 85 years and over (Jorm & Henderson, 1993). With the increasing number of older people in hospitals, more people with delirium or dementia will need appropriate care.

Given that dementia in older people is often under-diagnosed, it is important to identify people with cognitive impairment early in their care, preferably on admission, and to actively manage their condition.

A number of Health Services have looked at ways to improve the care of confused people in hospital. Some have employed cognition nurses who provide ward staff with specialist support and education while others have looked at separate, secure wards that have a higher nurse/patient ratio, a design that enables people with dementia to wander freely, good access to toilets, and high–low and low–low beds.

Health Services are encouraged to implement practice based on best evidence to avoid or reduce their use of physical or chemical patient restraints, which have been shown to increase the risk of adverse events.

Reducing problems with medication

Approximately 10–20 per cent of all adverse events occurring in hospitals in Australia are adverse drug events. Further, 7 per cent of emergency department attendances are medication related and 2–3 per cent of hospital admissions are a result of drug overuse or underuse or other adverse drug events (Safety and Quality Council, 2002).

The inappropriate use of drugs results in 140,000 hospital admissions in Australia annually, at a cost of $380 million (Safety and Quality Council, 2002).

Older people are more likely to be taking more than four different drugs and, because of this, are more likely to experience an adverse drug event. Delirium and falls are two well established complications of poor medication management in hospitalised older people and both are associated with increased morbidity and mortality (Inouye et al., 1996).

Health Services should ensure that:

- staff review the medication regimen of all older people at admission or presentation
- medical and nursing staff are educated about specific medication issues in relation to older people

- older people receive appropriate medication instructions and information to reduce errors when the older person returns home
- staff initiate safe prescribing procedures to reduce the risk of adverse events and prescribing errors
- on discharge, a medication and treatment summary is provided to the person's GP.

To reduce the danger of confusion when a person's medication regimen has been changed during the hospital stay, many hospitals take responsibility for supervising and supporting people's medication management when they leave hospital. Some Health Services have community liaison officer as a link to older people and carers when they return home. Others have a pharmacist, nurse or GP conduct post-discharge visits as part of discharge practice, to help patients comply with the medication regimen. It is also important to liaise with the older person's GP about their medication regime on return to the community.

Processes used to reduce the risk of medication errors should be informed by the *National guidelines to achieve the continuum of quality use of medicines between hospital and the community* (Commonwealth Department of Health and Family Services, 1998).

Supporting the maintenance of self-care

Some older people may have difficulty caring for themselves as they become more frail. Hospitalisation may exacerbate these issues if the person does not find the hospital environment conducive to self-care and their routine is disrupted.

Hospital staff need to recognise any problems in the older person's ability to self-care and provide additional support, while encouraging independence in people who can manage alone.

Where possible, Health Services should provide environments that are conducive to self-care (for example, adequate privacy for changing clothes, bathroom facilities that older people can use with easy-open taps, easy-open packaging for meals).

Dental and oral disorders are common among the elderly. Adequate attention should be given to the older person's oral hygiene, and assistance with oral care offered, if appropriate.

In the same way, consideration of the older person's feet is also important because if foot care issues are if not addressed, they may result in infection or reduced ability to move safely. Health Services should be aware of these issues and refer older people to the appropriate specialist when necessary.

Although most of these care issues are not life threatening, they may have systemic effects and can greatly reduce an older person's quality of life.

Managing depression

Depression frequently occurs in older people when they face coming to terms with reduced and deteriorating physical health and mental functioning, grief over a decrease in their independence or when mourning the loss of a loved one.

Also, as more older people are living alone, they may feel socially isolated and experience depression. Several studies have shown an independent association between depressive symptoms and increased mortality (Bula et al., 2001).

Older people in hospital suffering from depression may also experience functional decline and are more likely to have a longer stay, be readmitted and ultimately, be placed into residential care (Bula et al., 2001). In addition, depressive symptoms in older people are associated with increased average costs in both acute and rehabilitation services (Bula et al., 2001).

Older people suffering from depression may also be more vulnerable when faced with a change to their condition, or after a long period of hospitalisation, due to their often poor social support system.

Recognising and treating depression produces better health outcomes for older people. The Geriatric Depression Scale has been shown to be a useful tool in detecting depression and, if appropriate, should be followed by a comprehensive assessment involving the older person and their carers. This assessment should form the basis of a treatment and care plan.

Summary: specific care issues for older people

Principle 1:

Health Services apply practice based on best evidence to the care of older people, including specific attention to the risk of malnutrition, decreased functional mobility, loss of skin integrity, incontinence, falls, the development of delirium, problems with medication, poor self-care and depression.

Key objective

1.1 That older people under the care of Health Services receive care that is based on best evidence.

Action areas for Health Services

- Staff need access to evidence-based information and advice and encouragement in implementing this.
- Older people and their carers should receive information about risk factors associated with functional decline during hospitalisation.
- The physical environment and patient management practices should be audited for factors that contribute to the risk of adverse events during hospitalisation.

Implementation issues

- The department will work with the field to develop a Web-based resource for practice based on best evidence for the treatment and care of older people.
- The department, together with Victorian Quality Council (VQC), will work to progress the priorities outlined in the *VQC Strategic Plan 2002–2005* to respond to known problems and risks in the hospital setting.

Section two: Improving care–principles and processes

This section outlines:

(1) the principles that underpin the care of older people, including the involvement of older people in their own care

(2) the processes involved in delivering treatment and care, from the initial risk identification through to ongoing management of people with complex conditions.

Older people in our community come from a variety of cultures, backgrounds and experiences. This means that their care requirements will vary. It is important that Health Services recognise these differences and aim to provide culturally appropriate treatment and care. This can be achieved by tailoring the care to the individual's needs and considering the needs of their carers

Older people usually have ongoing contact with the health care system through regular visits to general practitioners (GPs), allied health clinicians and other primary care service providers. Health Services are aware of primary care service providers and should work to ensure their continuing involvement in the older person's care.

The department encourages treatment systems that are person-centred and enable people to have integrated, coordinated care and to move through different parts of the health service system as their clinical and care needs change (Department of Human Services, 2003a). It also recognises that people with chronic and complex care needs will require support from Health Services at different intensities and times throughout their lives.

Older people often need a holistic, problem-solving approach to their care. To achieve this, they first need to be risk screened, and if the risk screen is positive, they should receive a comprehensive assessment. It is also important that the person is involved in developing their interdisciplinary care plan, including the planning for their transition back to the community, and that they have their care coordinated through a single point.

In the inpatient setting, Health Services should also pay special attention to the issues described in the previous section (Section one), to help avoid or alleviate the occurrence of adverse events such as malnutrition, decreased functional mobility, loss of skin integrity, incontinence, falls, development of delirium, problems with medication, poor self-care and depression.

Valuing diversity

Victoria is a population rich in culture and language. Approximately 43.5 per cent of the Victorian population was either born overseas or has at least one parent who was born overseas, and more than 900,000 people speak a language other than English at home (Victorian Office of Multicultural Affairs, 2002).

Victorian Government policy requires that Health Service agencies are responsive to the needs of people from culturally and linguistically diverse backgrounds; that they face no barriers in accessing services, they are treated with respect and dignity, and

are supported in ways that meet their particular needs (Victorian Office of Multicultural Affairs, 2002).

Funded agencies have a responsibility to provide care that takes the person's individual needs and preferences into account, where possible, including preferences based on religious beliefs, linguistic or cultural background.

Health Services should ensure that people with low English fluency have access to professionally accredited interpreters and translated information to assist them in making informed decisions about their health care. The Victorian Office of Multicultural Affairs guide *Improving the use of translating and interpreting services*, provides direction to agencies on obtaining quality language services for their clients.

Considerable diversity exists amongst people with a disability who are ageing, both in terms of type and severity of disability and differential rates and impact of the ageing process. By taking a person-centred approach, Health Services can assess each individual's needs and formulate a care plan that meets the person's and their carers' requirements. Health Services need to make sure that their staff receive training and support to understand and meet the treatment and care needs of this group.

It is particularly important for health care providers to work with the older person with the disability and other people who may have a role in supporting the person's overall health and wellbeing. These people may include case managers, residential staff, advocacy representatives or the person's family and/or carer. GPs also play an important role in providing care for the person with a disability and often work to coordinate health care in the community setting.

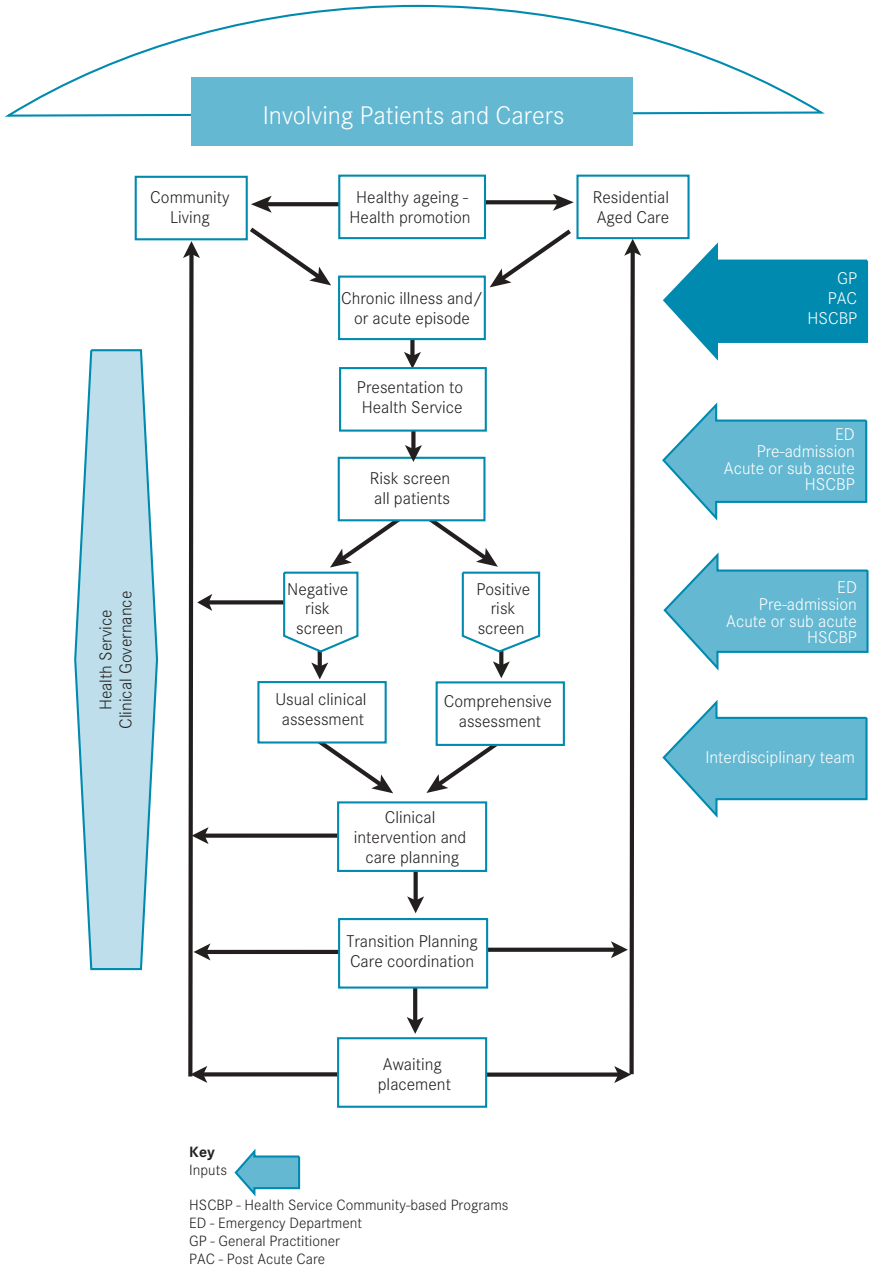
The important role of carers

Health Services are encouraged to acknowledge the role of carers in maintaining the health and wellbeing of older people. Carers (including family members and friends) can often provide valuable knowledge about the older person's condition, previous illnesses, behaviour and attitude and, therefore, should be included in discussions about treatment and care options (with the older person's consent). The carer's willingness and ability to be involved in the care of the older person should be discussed and taken into account when planning care.

A part of the holistic approach to care is to recognise that a person is often dependant upon the support of a carer if they wish to return to or continue living in the community. It is vital that carers are consulted in the assessment and planning process and that both the carer's and the older person's needs are identified when planning the transition back to the community. Health care professionals also need to be aware of the stress and difficulties that affect the carer and offer support where appropritate (for example, through access to carer support centres).

The following section examines the principles and processes that can be adopted by Health Services to ensure that older people receive the treatment and care that they require. Figure 3 illustrates these processes.

Figure 3 Health Service treatment and care processes and settings for older people



Clinical governance responsibility–working towards a better health care system

Health Services have a responsibility to ensure they provide older people with treatment and care that is based on best evidence.

Principle 2:
Health Services take clinical governance responsibility for the care of older people.

Clinical governance is a system for improving the standard of clinical practice. It ensures that clinical standards are met and that processes are in place for continuous improvement, backed by a new statutory duty for quality in health care (Starey, 2001). There are four key elements of clinical governance:

- clinical effectiveness
- risk management
- education and training
- consumer participation.

Tools for clinical effectiveness

Clinical effectiveness is a measure of the extent to which a particular intervention works. Key tools for coordinating and promoting action on clinical effectiveness include evidence-based practice, clinical guidelines, care pathways and clinical audit.

Clinical risk management–helping to reduce adverse events

Clinical risk management aims to reduce the rate and severity of adverse patient and organisational events through the active management of risks that threaten the provision of safe clinical care and efficient use of clinical resources.

Systematically assessing, reviewing and then seeking ways to minimise these risks can greatly reduce the incidence of adverse events. It is, therefore, important that Health Services know the key factors that place older people at risk of adverse events and implement appropriate interventions to eliminate or reduce these risks.

The importance of education and training

Lifelong learning and continuous development for health care professionals are essential components of good clinical governance. For health care professionals to provide effective care, they need to make sure that their own skills, knowledge and expertise are up-to-date. Health Services also have a responsibility to employ staff who are appropriately skilled and who understand the specific needs of older people and to provide their staff with opportunities to extend their knowledge and experience.

Consumer participation is key

The clinical governance framework encourages consideration of the community's perspective in the promotion of quality practitioner performance. This means involving people in their own care (and their carers, where appropriate).

Summary: clinical governance responsibility

Principle 2:

Health Services take clinical governance responsibility for the care of older people.

Key objective

2.1 That Health Services give specific attention to clinical effectiveness, risk management, education and training, and consumer participation in the care of older people.

Action areas for Health Services

- To provide Health Services' boards with regular information on issues relating to the care of older people.
- To ensure staff are aware of the key factors that place older people at risk of adverse events and take steps to implement appropriate interventions to eliminate these risks.
- To provide appropriate levels of education about the particular needs of older people for all professional staff.
- To provide safe and appropriate equipment to aid the delivery of quality care.

Implementation issues

- The department will request that the Australian Council for Health Standards includes aspects of care of older people in the Evaluation and Quality Improvement Program (EQuIP) Accreditation of Health Services.
- The department will revise the generic briefs for Health Service settings to ensure they address physical, social and environmental issues relating to the care of older people.
- The department will undertake an audit of Health Services' equipment that is used in sub-acute care, in the hospital and community settings, to establish recommended standards and identify current gaps in provision.

Involving older people and carers–the cornerstone to good health care

Principle 3:
Treatment and care provided by Health Services places the person at the centre of their own care and considers the needs of the older person's carers.

Health Services can better identify issues central to an older person's recovery by involving older people and, where appropriate, their carers, in planning care and treatment. For example, this may help to identify issues that could prevent or delay the person's return home.

To become more person-centred, Health Services need to consider and understand the needs of the older person's carers. For example, sometimes the older person themselves may be a carer and be anxious about the care of a person at home, both during and after their hospital stay. Or the carer may be an adult child of the older person with other significant care responsibilities or an equally elderly spouse. They may be stressed, burdened and fatigued by the current illness and deterioration of the older person.

Clear communication with the carers and the older person's GP is essential to ensure everyone understands the treatment goals and prognosis and to promote the person's recovery.

Where an older person is deemed to be mentally incompetent and unable to make appropriate decisions about their care, a nominated family member or guardian needs to be involved in decision making on the older person's behalf.

The ability of the carer to continue in their role in both the short and long term will affect the ability of the older person to return home and the level of community support that will be required for the person's transition from hospital.

Levels of involvement

Health Services are encouraged to involve older people and their carers on two levels. Firstly, they should involve older people in care planning and treatment. Secondly, they should seek systematic feedback on their service delivery.

As part of their quality improvement program, Health Services can use methods such as focus groups, telephone follow-up, liaison with consumer representatives and the Victorian Patient Satisfaction Monitor (Patient Satisfaction Tool) (Department of Human Services, 2003b) to encourage older people and their carers to provide feedback on the care they receive. Services can then use this feedback to improve their facilities and practices.

Summary: involving older people and carers

Principle 3:
Treatment and care provided by Health Services places the person at the centre of their own care and considers the needs of the older person's carers.

Key objectives

3.1 That older people and, where appropriate, their carers, are actively engaged in care planning processes.

3.2 That older people and their carers are given the opportunity to provide feedback that is used for quality improvement purposes.

Action areas for Health Services

- To provide guidelines/information to older people and carers that explains the options and processes available to them in planning and delivery of their care.
- To provide information in a variety of formats to ensure that people with hearing or sight impairment and people from culturally and linguistically diverse backgrounds, can access and understand the information.
- To ensure that older people and their carers can easily recognise and use systems for providing feedback on Health Service performance.
- To provide training for staff on person-centered goal setting and the involvement of older people and their carers.

Implementation issue

- The Victorian Patient Satisfaction Monitor (Patient Satisfaction Tool) is currently used only in acute settings, but should be extended for use in sub-acute settings. The department will also develop a patient satisfaction system for use in community settings.

Identifying people with additional care needs

Principle 4:
Health Services identify older people at risk of adverse health outcomes and/or having existing or potential supportive care requirements.

Risk screening tools can play an important role in identifying people who are at risk of adverse health outcomes or need supportive care. It is recommended that everyone presenting at a Health Service undergo a risk screen (including those entering the Health Service from the emergency department, pre-admission clinic, direct admission or through use of the Health Services' community-based programs).

The importance of risk screening

As part of the Effective Discharge Strategy, Victorian Health Services have implemented the Risk Screening Tool (Appendix A), developed by Thomas and Associates and validated for use in identifying discharge and care coordination issues.

The purpose of this risk screen is to flag any discharge and care coordination issues, which can then be incorporated into the post-discharge plan. If the person being screened is admitted to hospital and currently uses ongoing community support services, it is important that their service provider is notified.

In addition, it is recommended that all older people be screened to have their risk of adverse health outcomes identified. Recent work by the Acute to Sub-Acute Breakthrough Collaborative has produced risk screening tools that Health Services can use to detect the likelihood of adverse events and functional decline for older people.

Based on this work, the department will expand the Effective Discharge Strategy Risk Screening Tool so that it can also be used to identify the risk of adverse health outcomes for the older person. The expanded tool will then be validated for use across Victorian Health Services.

Summary: identifying people with additional care needs

Principle 4:
Health Services identify older people at risk of adverse health outcomes and/or having existing or potential supportive care requirements.

Key objective

4.1 That Health Services screen older people for the risk of adverse health outcomes or having existing or potential supportive care requirements.

Action areas for Health Services

- Once the Risk Screening Tool has been expanded and validated, Health Services will use the tool to identify older people at risk of adverse health outcomes and/or existing or potential supportive care requirements.
- Staff need to be trained in the effective use of the expanded Risk Screening Tool.

Implementation issues

- The department will work with Health Services to expand and validate the Risk Screening Tool so that it also screens for the risk of adverse health outcomes in older people.

Assessing care needs

Principle 5:
Treatment and care provided for older people with a positive risk screen includes the completion of a comprehensive assessment.

Older people often have a number of co-morbidities. As noted earlier, of the people aged over 70 years who are admitted to Victorian hospitals for multiday stays, 63 per cent have four or more diagnoses, as well as social and psychological care needs and issues (Department of Human Services, 2001–02a).

To ensure Health Services identify these needs and issues and commence appropriate care and treatment, it is recommended that trained staff thoroughly assess people who are over 70 years of age and have a positive risk screen.

Older people benefit from a comprehensive, interdisciplinary assessment and a holistic rehabilitative approach due to their often complex care needs (Luk et al., 1984).

Comprehensive assessment equals comprehensive care

A comprehensive assessment of older people differs from a standard medical evaluation by including non-medical domains, emphasising functional ability and quality of life, and relying on interdisciplinary teams. A comprehensive assessment also includes elements of assessment of carer needs.

The comprehensive assessment aids in the diagnosis of health-related problems, development of plans for treatment and follow-up, coordination of care, determination of the need for and the site of long-term care, and optimal use of health care resources (Beers & Berkow, 2003).

It is important that the comprehensive assessments, plans and interventions developed for an older person include attention to the principal domains of functional ability, physical health, cognitive and mental health, availability of carers and socio-environmental situation. This includes the key risk factors for adverse events for older people identified previously: malnutrition, decreased functional mobility, loss of skin integrity, incontinence, falls, the development of delirium, problems with medication, poor self-care and depression. Assessment should also build on existing information about the older person.

Interdisciplinary teams get results

A comprehensive assessment of an older person is most successful when conducted by an interdisciplinary team.

Interdisciplinary teams are defined as having an approach to care in which team members from different disciplines collectively set goals and share resources and responsibilities.

Not all older people require an interdisciplinary team approach. However, older people who have complex medical, psychological and social needs will benefit from this approach since teams are usually more effective in assessing people's needs and creating an effective, integrated care plan than professionals working alone.

Older people and carers are also part of the interdisciplinary team and existing care providers, such as GPs, should also be given the opportunity to provide input. Carers of older people with complex needs can benefit from an interdisciplinary approach as their strengths and needs are incorporated into the care plan (Beers & Berkow, 2003).

Summary: assessing care needs

Principle 5:

Treatment and care provided for older people with a positive risk screen includes the completion of a comprehensive assessment.

Key objectives

5.1 That every person over 70 years of age who is identified by the screen as at risk of adverse health outcomes and/or having existing or potential supportive care requirements has a comprehensive assessment, including identification of carer needs.

5.2 That Health Services take an interdisciplinary approach in assessing the care of older people.

Action areas for Health Services

- To use a recognised comprehensive assessment tool that covers the major adverse risk factors for older people. Staff need to be trained in the effective use of this tool.
- That appropriate management of any risk factors identified be integrated into the older person's care plan.
- To assess older people and then reassess them over appropriate time intervals to reduce the risk of misdiagnosis or unnecessary treatment. Health Services should build all assessments on existing information, where possible. If relevant, this information should be shared (with the person's consent) and health service protocols should support this information-sharing process.
- To make ACAS, gerontic specialist staff and the aged psychiatric mental health service available for consultation when required, wherever older people may interact with the Health Service.
- If the older person's ongoing care needs are likely to increase after their return to the community, the older person should be referred to an ACAS.

- To reassess people recovering from an acute or sub-acute episode who have been assessed as requiring residential care before they enter such care. This will account for any functional gains that the older person might have made in the interim.

Implementation issue

- The department, together with Health Services, will further the development of a validated, interdisciplinary comprehensive assessment tool for older people.

Planning care

Principle 6:
Treatment and care provided for older people includes interdisciplinary care planning that is founded on evidence-based care pathways.

Care planning is optimised when using an interdisciplinary approach. This means that the goals of the older person, and their carers where appropriate, become the focus of the care plan, with the team of health care professionals working together to plan for care that meets this goal.

Older people, and people with complex care needs who may have multiple conditions, may benefit from Health Services developing care pathways that incorporate a number of treatment and care processes. Health Services have already developed care pathways for many of the conditions that affect this patient group. It is important that care pathways interact positively with each other to provide holistic person-centred care.

Linking assessments and care plans

A good starting point is to link assessments to care plans with appropriate interventions where risks and care needs are identified. Assessments, plans and interventions should include attention to the risk of malnutrition, decreased functional mobility, loss of skin integrity, incontinence, falls, the development of delirium, problems with medication, poor self-care and depression.

They can also build on existing information about the person. It is recommended that care plans cover issues that have been flagged in relation to the older person's support requirements on return to the community. Where the person has previously received ongoing community support services, it is also important that the provider of these services and the person's GP be notified and involved in the care planning if appropriate.

In addition, the opportunity for discussion during care planning can be used for the older person and their carers to develop their future care and palliation wishes. This may take the form of a 'Refusal of Medical Treatment Certificate' or through the older person appointing a medical power of attorney.

The Handicap Assessment Resource Tool

Some Health Services have trialed the use of a handicap measure to encourage a person-centred approach to defining and monitoring care goals. The Handicap Assessment Resource Tool (HART) has been found to be effective and easily administered by health care professionals.

The person's personal care handicap refers to the person's abilities and restrictions in usual self-care activities. Administration of the measure is part of the care planning process and involves the person, their carers and GP, where appropriate.

The use of this tool has been particularly effective in promoting an interdisciplinary approach to care, basing recovery goals on the person's needs and identifying when a person is ready for discharge and the issues that will require supports and services back in the community.

Summary: planning care

Principle 6:
Treatment and care provided for older people includes interdisciplinary care planning that is founded on evidence-based care pathways.

Key objectives

6.1 That Health Services use evidence-based care pathways for major clinical conditions.

6.2 That a coordinated care plan is developed for all people whose risk screen has identified existing or potential supportive care requirements and transition issues.

6.3 That older people who have undergone a comprehensive assessment will have an interdisciplinary care plan developed. This care plan will be based on the person's and, where appropriate, their carer's, goals and bridge the person's transition from hospital to the community.

6.4 That older people participate in their care planning as part of an interdisciplinary team. The person's GP, existing ongoing community support provider and carers are included in the interdisciplinary team.

6.5 That care planning includes discussion with the older person and their carers regarding their future care and palliation wishes.

Action areas for Health Services

- To allow older people with complex care needs to be involved in the care planning process, along with their GP and carers, where possible.
- To provide older people with information about the Medical Treatment Act 1988 and medical power of attorney upon request.

- To use the HART to encourage a person-centred approach to planning care and to determine whether a person can move to a lower care setting or return home.
- To expand the use of care pathways for conditions that affect older people to ensure best practice management in these areas.

Implementation issues

- The department will provide information on the Medical Treatment Act through professional and community education and ensure information is available through the department's website at www.dhs.vic.gov.au/mta
- The department will work with Health Services to assist with staff training in the use of the HART.
- The department will work with Health Services to assist them to develop and implement care pathways and make this information accessible to all Health Services.

Transition planning and coordination of care

Principle 7:
Treatment and care provided for older people is coordinated to achieve integrated care across all settings.

The care of people who move across different levels of the health system needs to be coordinated to avoid delays and provide a smooth continuum of care. This need not be viewed as a new layer of administration within an already complex system but rather as the more efficient coordination of existing services. People assessed as having complex care needs should have a single person coordinate their care by working with them and their carers, where possible. Coordination of care should be provided in the hospital and also bridge the person's transition back to the community. This service should be continued until more appropriate long-term community care and/or case management options are available, usually for a period of up to 28 days.

Case management works best when based on the person's needs, as outlined in the care plan, and by involving the person's GP (who may be reimbursed for participation in the discharge care plan through the Enhanced Primary Care Medicare Benefits Schedule item) and ongoing community support providers, where appropriate.

Primary Care Partnerships (PCPs) are a voluntary alliance of primary care providers that work together to improve health and wellbeing in their local communities. PCPs aim to coordinate services to provide a platform for functional integration in the primary care sector.

Part of the work that has been undertaken by PCPs has been to develop processes and protocols that will improve the flow and transfer of information between agencies. This work has the following key goals:

- to reduce the burden on people of providing basic information about themselves
- to enable the transfer of common information between providers
- to reduce the administrative burden on agencies and providers by sharing basic consumer information (with consent).

The client information, privacy and consent PCP Service Coordination Tool Templates (SCTTs) assist in coordinating the care of people who require ongoing community support services and should be used when people are transitioning back to the community.

Any assessments or other relevant information about the person can be included with the SCTTs and passed to ongoing community support providers with the person's consent. On transition from the hospital, it is important that the person's discharge summary is sent to their GP and other relevant care providers (for example, the person's residential care provider).

The needs and abilities of carers should also be taken into account when planning the person's transition back to the community. Carers Victoria has developed a discharge checklist to assist health care professionals in including carers in transition planning (see Appendix B). Use of this list will help Health Services take the support needs and abilities of carers into account in developing sustainable care

Summary: transition planning and coordination of care

Principle 7:

Treatment and care provided for older people is coordinated to achieve integrated care across all settings.

Key objectives

7.1 That people assessed as having complex care needs have a single person coordinate their care by working with them and their carers.

7.2 That care coordination for older people is provided in both the hospital and the community to facilitate the older person's return to their usual residence, with ongoing support as required.

Action areas for Health Services

- To allocate a care coordinator, case manager or key worker to older people with complex care needs to facilitate their passage through the care continuum.
- To involve the person's existing community case managers, where applicable, in developing the person's transition arrangements.

- To refer 'at risk' people with complex conditions who do not have an existing community case manager to appropriate ongoing community support services and arrange time-limited case management through the Health Service until an ongoing community support provider is able to accept that role (usually for a period of up to 28 days).
- To involve the person's GP in discharge care planning.
- To incorporate the use of the PCP processes and protocols, and the PCP client information, privacy and consent SCTTs in coordinating the care of people transitioning back to the community.
- To take into account the needs and abilities of carers when planning the person's transition to the community.

Implementation issue

- The department will assist Health Services to implement the PCP processes and protocols.

Section three: Integrating care–principles and processes

This section focuses on the importance of providing appropriate care settings for older people. It also addresses the integration of care across settings and highlights the importance of relationship building between Health Services and ongoing community support providers.

Treatment, therapy and care for older people are provided in many different settings. This is because the boundaries between hospital and community care have changed over the last decade and many services previously provided in hospitals are now delivered in the community or in the person's own home.

Care settings should be designed and managed to meet the needs of older people. Where it is safe, appropriate and cost-effective, a person's choice of care setting should be accommodated.

It is also important to recognise the integral role that the person's carers play in their choice of care setting, in particular the carer's ability and willingness to provide different aspects of care.

Home care and community support services–a viable option

A number of conditions can be safely managed in the person's home and should be considered if a hospital admission is likely to exacerbate existing conditions, such as dementia. Many older people prefer to be treated in their home environment and this has shown to improve outcomes for many conditions. In some situations, however, particularly rural and isolated areas, this approach may not be safe or cost-effective.

Some people who are clinically stable will receive all of their treatment in their home setting. Other people may require part of their care in a hospital but will be able to complete their care in the community with the help of supplementary services. There are other instances where older people may present to Health Services and not need inpatient treatment, but could benefit from access to home-based or centre-based therapy services and supportive care services in the community.

Moving across care settings

Older people and people with chronic and complex health care needs who may require periodic episodes of care are more at risk than other patient groups of experiencing adverse events in hospitals. It is therefore important that, in moving through care settings, the care is provided in an integrated way to meet the older person's and carers' needs and that the environment is designed to reduce the risk of adverse events.

The following sections discuss settings that are appropriate for the care of older people and examine the importance of integration within Health Services' community-based programs, and between Health Services and ongoing community support services.

Improving hospital inpatient care for older people

Principle 8:
Older people receive treatment and care in the setting that best meets their needs and preferences, where it is safe and cost-effective to do so.

The physical state and design of hospitals in Victoria varies in age and style. In the past, hospitals have been staffed, designed and built to maximise efficiency, but this does not necessarily produce the best care model for older people.

Apart from paediatric and maternity units, all specialist and general medical units will have an increasing number of older people as patients (Department of Human Services, 2001–02a). Health Services, therefore, need to address a number of environmental issues to accommodate the needs of older people, including designing areas that older people can navigate easily and areas where they can eat and socialise. Health Services also need to recognise that many older people may have cognitive impairment, hearing loss, a visual deficit and/or mobility problems. Features such as signage and mobility aids (non-slip floors, rails) are extremely important.

In response to these issues, the Positive Ageing Foundation has written on the principles and elements that contribute to making 'age friendly hospitals' (Hegarty & Griffiths, 2002). Providing an appropriate physical environment is an essential element for making hospitals age friendly and 'will help to make hospital stays less stressful for patients and lead to quicker recovery times and shorter hospital stays' (Hegarty & Griffiths, 2002).

Emergency departments–creating appropriate responses to the needs of older people

Many older people presenting to emergency departments have a number of co-morbidities, which may include hearing difficulties, confusion and issues with continence and skin integrity. Long waits on trolleys or in noisy emergency departments can exacerbate these underlying conditions and ultimately lead to adverse events.

It is vitally important that staff have a strong awareness of the needs of older people, and plan their work practices and interaction accordingly. Health Services are encouraged to promote the placement of aged care teams, gerontic clinical nurse specialists and/or geriatricians in the emergency department.

In order to reduce the amount of time that older people spend waiting in the emergency department environment, some Health Services have developed processes whereby older people are provided with access to specialised inpatient areas. Other Health Services have provided older people with quiet areas in the emergency department where they can wait and where staff can provide timely supervision and monitoring of care.

Improving acute hospital settings

All Health Services need to:

- encourage a culture of person-centered holistic care
- ensure a focus on maintaining the older person's independence while recognising when they need assistance
- ensure they support programs that minimise the risks of adverse events (such as falls prevention programs, pressure injury prevention programs and medication reviews).

Older people should have access to specialist services available through Health Services, but should also have their treatment improved though a focus on delivering care that best meets their specific needs. Some Health Services have configured a ward that focuses on the acute care of older people, such as an Acute Care of the Elderly (ACE) ward. Practice and research evidence suggests that ACE wards improve functioning and reduce the need for residential care placement.

The staff complement of an ACE ward is different from the usual staffing of a general medical ward, with a higher ratio of allied health practitioners. In these wards, early specialist intervention by a geriatrician and allied health staff enables the treatment of older people with an acute illness while preventing functional deterioration in those with complex health care needs.

It is recognised that not all Health Services are able to reconfigure their wards into the ACE model; however, it is important that Health Services move to establish an ACE focus in all wards through the availability of appropriate staffing mix and settings for acutely ill older people with complex health care needs.

The importance of sub-acute hospital settings

Most people who go to hospital return to their usual residence without needing additional support from the Health Service. However, approximately 3 per cent of acute inpatients are transferred to sub-acute inpatient services and, of these, 64 per cent are over the age of 70 (Department of Human Services, 2001–02a).

Once medically stable, people who need further rehabilitation or who may benefit from further investigation and treatment should be accommodated in sub-acute settings. In a sub-acute setting, the emphasis shifts from managing the acute illness to eliminating obstacles to the person's return home and enabling them to reach an optimal level of independence.

The integration of therapy from hospital to home is improved when older people and carers, inpatient staff, home-based staff and centre-based staff have a close working relationship. The department encourages opportunities for staff to move between care settings to improve their understanding of the issues relating to the integration of services.

Centre-based rehabilitation should be co-located with inpatient services or other like services (such as community health services or health precincts) to encourage

service integration and shared administration and overhead costs. Also important is the provision of consultation liaison psychiatry in sub-acute settings, given the high levels of depression and anxiety among people with chronic illness.

Summary: hospital inpatient care

Principle 8:

Older people receive treatment, therapy and care in the setting that best meets their needs and preferences, where it is safe and cost-effective to do so.

Key objectives

8.1 That older people receive appropriate care in the appropriate setting.

8.2 That the hospital setting provides appropriate physical, social and environmental features to meet the special needs of older people.

Action areas for Health Services

- To manage inpatient settings in a way that maximises the functional independence of all people, particularly older people.
- To better meet the care needs of people with behaviours of concern who need acute treatment.
- To identify one point of contact for sub-acute inpatient service referrals from acute inpatient services and the community.
- To manage the care of older people so that they do not experience any delay in receiving allied health services and access to specialist medical services in acute and sub-acute wards.
- To expand or develop sub-acute community-based facilities to accommodate growing needs, as required.
- To co-locate sub-acute services with major acute services where possible.

Implementation issues

- Generic briefs for future capital developments will incorporate 'older person-friendly' planning and design features that meet the above objectives.
- The department will work with Health Services to address the provision of adequate levels of sub-acute services across Victoria.
- The department will work to address sub-acute workforce supply issues.

Health Service community-based programs

Principle 9:
Health Services integrate their community-based programs to provide the appropriate treatment, therapy and supportive care to meet the needs of older people.

There is an increasing recognition that treatment, therapy and support services in the community setting can play an important role in improving health outcomes for people with complex and chronic health care problems.

Health Services provide a range of community-based programs that recognise that a person's health care needs extend beyond the inpatient episode. Older people and their carers are the main beneficiaries of these programs.

Community-based programs produce positive health outcomes

Community-based programs provided by Health Services play an important role in enabling people to live independently, preventing functional decline and supporting carers. Health promotion and outreach services are strong elements of these programs.

Health Service's community-based programs can serve to prevent hospital admission, readmission and improve health outcomes by ensuring adequate treatment and supports are available to enable people to reach their optimal level of independence. Community-based programs provided by Health Services can also serve as an alternative to a hospital admission.

To streamline processes, Health Services are encouraged to promote a single entry point and referral system for their community-based programs. This entry point should be easily recognisable and be staffed by health care professionals who can refer the older person to treatment, therapy and care that meets their needs.

The older person's transition back into the community is often assisted through the time-limited use of Health Service's community-based programs. These programs play an integral role when basic maintenance and support services, such as HACC, may not be immediately available (due to resource constraints) or where the person is waiting for a more intensive level of community support, such as Linkages, Community Aged Care Packages (CACPs) or Extended Aged Care at Home Packages (EACH).

Acute care in the community–Hospital in the Home

Acute care at home (Hospital in the Home – HITH) consists of providing an appropriate level of treatment for a person's acute health care needs in the home. It aims to return a person to a state of wellbeing so that they no longer need treatment.

HITH is a safe, acceptable and cost-effective alternative to acute in-hospital care for a wide range of clinical conditions (North Western Health, 1999). Health services

should continue to identify conditions that can be safely provided in a person's home as an alternative to an inpatient stay.

A person admitted to the HITH program might have needs ranging from medical treatment to supportive care. The program is responsible for identifying the person's various needs via a comprehensive assessment and providing the full range of services the person requires.

As carers play a significant role in assisting in the care and support of HITH patients, it is important that their needs are also considered.

Sub-acute therapy in the community

Sub-acute therapy in the community is typified as a person-focused, interdisciplinary model of care that is oriented towards flexible service delivery. Its aim is to improve and maintain a person's functional capacity and maximise their independence.

Sub-acute community-based therapy is delivered in a person's home or at an ambulatory care centre (for example, community rehabilitation centre). When people receive part of their care at home, they may have improved outcomes and a reduced length of hospital stay (Rudd, 1997). This is because people are better able to learn the skills they require in their own home environment.

Sub-acute community-based therapy provides the following:

- a flow of care, where therapy in a community setting follows an inpatient episode of care
- time-limited, goal-centred episodes of therapy aimed at improving health outcomes
- the ability to reduce admissions and readmissions to inpatient services by providing people with home-based or centre-based therapeutic interventions that prevent the deterioration of an existing condition and improve functionality
- therapy for people to assist them in achieving the maximum level of reintegration into their community after an inpatient episode.

Health Services need to provide adequate community-based sub-acute services to meet the expected demographic growth trends among the main users of these services.

Supportive care in the community

Health Services also arrange and provide additional, time-limited community-based supports for older people who no longer need treatment services but do need a range of other services to assist them to return to optimal function and be independent in the community.

These supports are short-term and can be used in addition to pre-existing ongoing community support services. Older people often require additional short-term supports from the Health Service because ongoing community-based support

options cannot always be quickly accessed when a person is leaving hospital. Ongoing supports can include services such as basic maintenance and support from HACC or more complex care packages like Linkages, CACPs or EACH.

It is important that Health Services arrange and provide these short-term community supports to assist older people with recuperation and prevent functional decline until more appropriate long-term community care options are available, usually for a period of up to 28 days.

Short-term supportive care at home can include assistance with personal care, meals, some nursing and other support services. Health Services currently arrange supportive services through the Post Acute Care (PAC) program. Approximately 8 per cent of people discharged from Health Services access additional community care through the PAC program (Department of Human Services, 2001–02a) and, of the people using PAC services, around 44 per cent are over the age of 70 (Department of Human Services, 2001–02b).

Where possible, the department encourages Health Services to broker the purchase of short-term supportive care services from existing HACC providers. This will help facilitate the transition for people who need ongoing community support services.

The department also encourages Health Services to develop effective working relationships with ongoing community support providers who service their catchment population, in order to provide an integrated service for people.

Summary: Health Service community-based programs

Principle 9:

Health Services integrate their community-based programs to provide the appropriate treatment, therapy and supportive care to meet the needs of older people.

Key objectives

9.1 That community rehabilitation centres accommodate an expanded role as providers of integrated sub-acute community-based services.

9.2 That community-based programs provided by Health Services are integrated to provide appropriate treatment, therapy and supportive care, with a single entry point and referral system.

Action areas for Health Services

- To ensure the optimal duration of inpatient care for older people by providing appropriate acute, sub-acute and supportive care services in the community setting.
- To provide people with access to individual programs–such as the Post Acute Care program and sub-acute community-based services–via a single assessment and referral point.

Implementation issues

- The department will work collaboratively with Health Services to look at ways that sub-acute community-based services can be expanded according to identified needs.
- The department will work collaboratively with Health Services regarding their community rehabilitation centres to accommodate their expanded role as providers of integrated sub-acute community-based services.
- The department, in consultation with Health Services and key stakeholders, will develop appropriate accountability and funding measures for sub-acute community-based services.
- The Post Acute Care program may need closer alignment with Health Services. A range of issues, including impact on current program arrangements and funding and accountability measures, will need to be considered by the department and the field.

Relationships between Health Services and ongoing community support services

Principle 10:

Robust protocols and agreements developed between Health Services and ongoing community support providers ensure that older people continue to receive the care they require in a coordinated and integrated manner.

Health Services are increasingly realising the importance of building relationships with ongoing community support providers. These include HACC agencies such as local government authorities, district nursing services, community health centres and providers of packages for people with more complex support needs such as Linkages, together with providers of residential care, EACH and CACPs.

The interface between Health Services and ongoing community support providers is developing and the two areas need to actively work together to ensure that older people experience an integrated and effective transition from the hospital back to the community.

Informing GPs is critical in care of older people

Health Services need to ensure that GPs are kept informed and given the opportunity to be involved in their patient's transition from hospital back to the community. The health system in Victoria has conducted projects aimed at increasing GPs' involvement in preparing transition plans, sharing patient care and working with hospital colleagues to develop disease-focused care pathways. GPs should be able to identify a single entry point to Health Services (as mentioned previously) and refer patients for community-based programs provided by Health Services directly, rather than sending them via the emergency department.

Applying protocols and agreements

Health Services require robust protocols and agreements with ongoing community support providers to ensure hospital services are used for appropriate responses. This will involve developing an understanding of the types of services provided by different agencies and an appreciation of the constraints under which they operate.

It is recommended that Health Services provide or facilitate access to short-term care to enable people to return home. This is in line with other expectations of Health Service support, such as the provision of aids, equipment and oxygen.

In most cases, it is expected that this support would be for a maximum of 28 days. During this limited period of support provided by Health Services, arrangements can be made for the usual ongoing community support providers to meet the older person's long-term needs. Where an older person received ongoing community support services prior to their hospital admission, this care would be expected to continue and the Health Service would fund or provide only the additional services needed as a result of the acute or sub-acute episode.

To help facilitate good transition and ongoing support, it is important for Health Services to find out from older people at the point of admission whether they are receiving ongoing community support services at home and to notify the provider of the person's admission to hospital. It is also important for Health Services to involve the person's usual service provider in planning care on discharge from hospital. Through this involvement, providers can better plan for meeting the ongoing support needs of older people.

Integrating services improves health service delivery

Resource constraints and ongoing community support program protocols sometimes place limitations on the capacity of community-based services to respond quickly to Health Services' approaches for supportive care for older people being discharged from acute services. The lead-time required for planning in-home service delivery is generally longer than the time frames in which Health Services usually work and Health Services need to be aware of these difficulties.

Recent projects funded through the Hospital Admission Risk Program (HARP) have identified specific disease management models that are conducive to shared care arrangements and protocols. Similarly, older people with complex care needs can benefit when the Health Service and the ongoing community support provider take an integrated approach to their treatment and ongoing supportive care.

The interface between services provided by Health Services and services provided by ongoing community support providers is an important one. This interface needs clear protocols, understanding and goodwill to ensure that people with complex care needs have the support they require provided in a coordinated and integrated way. The adoption of common processes, for example, a fee structure that is consistent across Health Service community-based programs and community care providers, will need to be developed.

Primary Care Partnerships service coordination

A core goal for PCP service coordination is to provide a platform for functional integration in the primary care sector. Functional integration means that agencies will retain their organisational autonomy, while agreeing to share information and conduct particular functions in an agreed way.

PCPs have developed and implemented common processes, protocols and systems to integrate the way in which people's needs are identified and assessed, and the way in which care is planned and managed (Department of Human Services, 2001a).

Enhancing the flow of the person's information between service providers and providing a common, agreed set of information, is fundamental to developing functional integration. Health Services should use the appropriate PCP SCTTs for communicating client demographic information, privacy information and consent to community-based providers.

Assessments and care plans should be shared between the Health Service and ongoing community support provider so that subsequent assessments and care planning can build on existing information. In the same way, when a person admitted to a Health Service has already received community services, the person's information should be provided to the Health Service (with the person's consent) to avoid duplication.

Summary: relationships between Health Services and ongoing community support services

Principle 10:

Robust protocols and agreements developed between Health Services and ongoing community support providers ensure that older people continue to receive the care they require in a coordinated and integrated manner.

Key objectives

10.1 That older people experience integrated care (and case management where required) through coordination between Health Services and ongoing community support providers.

10.2 That Health Services arrange supportive care services, where required, for a maximum of 28 days to enable the person to return home. (There may be exceptions and a degree of flexibility needs to be maintained to ensure that a person receives the level of care they require).

10.3 That post-discharge, ongoing community support providers continue to provide up to the level of service that the person received prior to their hospital episode. Health Services will facilitate this by notifying providers when a client has been admitted and indicating a likely discharge date.

10.4 That Health Services ensure their time-limited supportive care programs have similar processes and protocols to ongoing community support providers to enable the older person and their carer to move smoothly between providers.

10.5 That Health Services participate in the service coordination work of their local PCP.

Action areas for Health Services

- To apply a time limit of 28 days to the provision of supportive care services. This time limit is a guideline only and Health Services need to ensure that an older person receives appropriate supports until they have either returned to independence or are able to access more appropriate ongoing options. This time limit does not apply to therapy services (for example, sub-acute community based services).
- To use common processes and protocols in all community-based programs that are provided by Health Services, to link with PCPs, avoid duplication and streamline service provision.
- To undertake significant work with ongoing community support providers to work though the implications and issues involved with these changes.
- To work with GPs and ongoing community support providers to make available an integrated service preventing unnecessary admissions and encouraging better outcomes for older people.
- When a person is hospitalised, the health care team should inform their GP and ongoing community support provider and involve them, wherever possible, in case conferencing, care planning, sharing of information and decision making.

Implementation issues

- The department may need to provide change management project support to enable Health Services and PAC services to manage the organisational change involved in achieving the key objectives.
- Some Health Services are already integrating their services, using a single entry point. The department will look at ways of sharing these services' change management processes and learnings with other Health Services.
- The department will look at progressing the development of electronic health records.
- The department will develop an appropriate accountability measure and performance indicators in relation to the provision of time-limited community-based programs by Health Services.
- The department will examine current fee policies for community-based programs provided by Health Services to gain consistency between the sectors.

Older people awaiting long-term care options

Principle 11:
An adequate level of support for people awaiting long-term care options is provided in the setting that best meets their needs.

The Australian Government has responsibility for providing long-term residential aged care and higher level community support packages. Benchmarks have been developed by the Australian Government to identify the number of residential care beds and packages that will be supplied to each state and territory.

The level of local access to residential care and community support packages will have an influence on the degree of choice and waiting times for people seeking long-term care in hospital and community settings.

In 2000–01, 52 per cent of people assessed by the ACAS in hospital were recommended for residential care (Lincoln Gerontology Centre, 2002). Victoria has the lowest ratio of operational residential care places to the 70 years and over population of any Australian jurisdiction (Productivity Commission, 2002). Given the time lag between the allocation of additional resources and opening of new beds, the gap between the ratio of operational places and the planning benchmarks is unlikely to be bridged in the medium term.

Moving to residential care

Moving to residential care is often stressful for older people and their carers. Health Services are under pressure to discharge people from the acute and sub-acute settings once they no longer require this level of treatment. However, even with good processes and access to residential care, families are likely to need at least two weeks to find suitable accommodation once a family member has been assessed as needing residential care. They may also be experiencing significant feelings of grief and loss at this time.

To assist families and carers with decision making, Health Services should provide timely information on care options and the opportunity to discuss these alternatives, as well as a supportive environment.

Dealing with lack of residential care availability

Where there is a lack of operational residential care, large numbers of older people requiring residential care often remain in hospital long after they have completed their episode of acute or sub-acute care (Department of Human Services, 2002C).

This causes problems as the acute and sub-acute inpatient setting is no longer appropriate for this group of people and it can also mean that other older people who require acute or sub-acute care have their access to these services delayed.

Some Health Services with major difficulties placing people requiring residential aged care have implemented short-term alternatives such as interim care. In some

cases, the department has provided specific funding for this purpose. In other cases, Health Services have used existing funding streams or reconfigured their service model within their existing budget to develop an interim care service.

The interim care program

An interim care program provides temporary support and active management for older people who have completed their acute or sub-acute care, as well as social work and case management support to assist families to obtain longer term care.

Not every older person who is assessed as requiring residential care will need to use an interim care program. Nor will all Health Services need to develop a formal interim care program, given the variable internal and external circumstances in which Health Services operate.

The evaluation of five interim care pilots completed in 2002 (Department of Human Services, 2003c) indicates that:

- interim care services played a positive role in facilitating the flow of patients through Health Services
- a small proportion of older people were able to remain at home after a period of time in interim care, often with ongoing community supports in place
- where interim care is appropriate, it is advisable that both home-based and bed-based options be available.

The department believes that there is considerable scope for Federal/State cooperation to improve transition between hospital and long-term care. Within resource constraints, Victoria will consider opportunities to work with the Australian Government to explore new service models that are appropriate to the Victorian context and priorities.

Summary: older people awaiting long-term care options

Principle 11:

An adequate level of support for people awaiting long-term care options is provided in the setting that best meets their needs.

Key objectives

11.1 That people who have been assessed in hospital as requiring residential aged care continue to receive appropriate care from Health Services.

11.2 That Health Services assist people and their families to obtain timely access to long-term care.

Action areas for Health Services

- To take account of the interim care guidelines developed by the department.

- To provide both bed-based and home-based options, where an interim care service operates.
- To facilitate the older person's move to residential care in a way that recognises the psychosocial issues that may be experienced by the older person and their carers.

Implementation issues

- Given competing departmental funding priorities, funds for any new interim care service will be carefully targeted to where there are significant problems with access to residential care. The department will monitor, review and possibly modify levels of interim care over time.
- The department may need to assist some Health Services to review their internal processes by sharing the successful approaches of other Health Services.
- The department will aim to work with the Australian Government Department of Health and Ageing to improve access to residential care and high level community support packages.

Promoting health independence

Principle 12:

All people across Victoria have access to Centres Promoting Health Independence.

Older people, and people who have multiple and complex needs, often require access to specialist assessment and treatment and a variety of support services to be able to maintain their independence in the community.

There is currently a greater emphasis on the management of chronic conditions as part of joint arrangements with GPs, hospitals and community service providers through various integrated disease management programs. These and similar programs benefit older people as they are more likely to need to access various support programs and services.

Older people can benefit greatly from joint management of specific chronic conditions through partnerships, such as those occurring through HARP. At present, some of these programs may be difficult to identify and have separate criteria for eligibility and separate processes for referral assessment. PCPs are bringing together many of these programs and simplifying the processes; Health Services should adopt the same tools and processes.

Refocusing and developing existing services

Health Services provide a number of programs that support the independence of older people, including inpatient services, centre-based and home-based rehabilitation, specialist assessment and management.

Services such as multidisciplinary clinics providing assessment and treatment for conditions affecting older people, for example, the cognitive, dementia and memory assessment services (CDAMS), continence clinics and falls and mobility clinics, also play an important role.

To enable greater access to programs, these services should be co-located or develop strong links with community services, such as programs providing aids and equipment, ACAS, programs providing packages of care, GP clinics and HACC programs. Such arrangements already exist at most extended care centres and at some major sub-acute facilities. The refocusing and further development of these sites will promote the integration of appropriate services. These co-located services should develop a high profile as Centres Promoting Health Independence.

Centres Promoting Health Independence

These centres will help strengthen people's health independence from two perspectives. Firstly, they will reduce the need for hospital admission by providing community-based therapeutic interventions that may improve a person's function or prevent the deterioration of existing conditions. Secondly, people who have experienced an inpatient episode will be supported to achieve the maximum level of reintegration into the community.

Centres Promoting Health Independence should be available to people of all ages who need sub-acute care and access to specialist diagnostic, therapeutic and rehabilitation services. The centres should be developed and promoted not just as providing treatment and care services, but as a resource that enables older people to maintain their optimal independence in the community (for example, by enabling an arthritis support group to use the hydrotherapy pool and providing healthy ageing information). The centres should work collaboratively with all Health Services in their region to support the delivery of quality services.

Summary: promoting health independence

Principle 12:

All people across Victoria have access to Centres Promoting Health Independence.

Key objectives

12.1 That existing extended care centres and some major sub-acute facilities are refocused into Centres Promoting Health Independence, with at least one designated centre in each departmental region.

12.2 That Centres Promoting Health Independence:

- provide a significant sub-acute inpatient service, with the size dependent on the catchment population

- provide or facilitate access to a range of sub-acute community-based services to enable people living in regional and remote areas to access clinical expertise, including centre-based and home-based services, cognitive, dementia and memory services, continence clinics, falls and mobility clinics and mobile outreach services
- are a focus for the development of statewide specialist services that provide health care professionals with additional skill levels and access to a wider support network for the management of people with complex needs
- where possible, co-locate with ACAS, aged psychiatric and mental health services and community support programs (such as community aged care packages) to provide a recognisable facility that supports people, particularly older people, to remain in their community
- provide access to a hydrotherapy pool
- are a recognised point of access (from the community or from acute services) to services for the prevention, treatment and management of disabling conditions
- are outward-focused community resources that provide information, services and facilities to older people and people with a disability.

Implementation issues

- The department will produce a generic brief for Centres Promoting Health Independence to ensure they address physical, social and environmental issues relating to the care of older people.
- Major extended care centres will be refocused into Centres Promoting Health Independence. Where there is not a distinct facility already identified in a region, the major sub-acute provider in that region will be redeveloped, as resources become available, to take on the additional role as a Centre Promoting Health Independence.
- The department will work with Health Services and relevant key stakeholders in developing their capacity to provide outreach services from their Centre Promoting Health Independence.

Conclusion

Older people are significant users of Health Services due to their greater medical complexity and care requirements. As the number of older people in Australia increases, it is essential that Health Services view older people as their main client group, develop a culture that supports this view and implement processes to meet the specific needs of older people.

This paper has focused on improving the care provided for older people by Health Services and integrating care across settings to ensure that people have the appropriate care in the appropriate place.

Three fundamental issues have emerged in considering how to improve and integrate the care of older people:

- Health Services must adopt a strong person-centred approach to the provision of care and services.
- Health Services should better understand the complexity of older people's health care needs.
- Health Services must improve integration within their community-based programs and between Health Services and ongoing support services available in the broader community.

Older people at the centre of their care

One of the major principles in this paper is placing older people at the centre of their own care and working in partnership with them to provide care that best meets their needs. As Health Services develop opportunities for older people to contribute to the planning and provision of their health care, it is envisioned that this partnership approach will change the culture of Health Services and move them towards greater responsiveness to older people's needs, which will ultimately improve their health outcomes.

Health Services need to work collaboratively with carers. The presence of a carer is often the significant factor enabling an older person to remain living in, or to return to the community. However, caring also has consequences for the people supporting the older person and health care professionals need to be aware of the stress and difficulties that affect the carer when planning the transition from the hospital setting.

Specific care needs

Although much has been achieved over recent years to improve their care, older people often experience adverse events and poor health outcomes following admission or presentation to Health Services. This paper has highlighted the specific care issues for older people and identified the principles and processes that need to be in place to meet their needs and prevent functional decline.

Improving care processes

This paper has also looked at processes necessary to provide improved care for older people. These include identifying people needing additional treatment and support, assessing care needs, and integrating appropriate interventions to avoid adverse events for older people.

Integrating care settings

The boundary between hospital and community care has changed over the last decade with a number of conditions now safely managed in the community. The paper highlights the importance of integrated care that meets the older person's and carers' needs as they move across care settings. The paper also identifies the need to look beyond the provision of direct care to consider the design and management of care settings so that appropriate physical, social and environmental features relating to the special needs of older people are provided.

The paper acknowledges that significant numbers of older people often remain in hospital after they have completed their episode of acute or sub-acute care while they are awaiting a residential care place (Department of Human Services, 2002c). The paper also acknowledges that the care provided in acute and sub-acute inpatient settings may not be the most appropriate for this group of people and suggests short-term alternatives, such as interim care, could be used.

Improving the interface

In order to resume and remain living independently in the community, many older people require ongoing community support services. The interface between Health Services and ongoing community support providers is an important one. The paper strongly supports the need for both community support services and Health Services to actively work together by agreeing on protocols and processes to ensure that older people experience an integrated and effective transition from the Health Service's care settings back to the broader community.

Promoting independence in the community

While acknowledging the need for older people to access acute and sub-acute care when they need it, the paper also supports the provision of preventative support services. Older people, and people who have multiple and complex needs, often require access to specialist assessment and treatment and a variety of support services to be able to regain or maintain their independence in the community. The paper identified Centres Promoting Health Independence as a resource that will enable all people (with a focus on older people) to receive the treatment and care services that they require in the community.

Improving care for older people: a policy for Health Services presents a practical vision for the future of care for older people provided by Health Services. The Government recognises that there is much work to be done in implementing the

principles that underpin this policy. However, many Health Services are already providing care that is focused on the best outcomes for older people.

This paper will improve the ability of Health Services to respond to their patients and prepare for the increasing number of older people who are likely to require care and treatment in the future.

Glossary

aged care assessment services (ACAS): work to assess the needs of frail older people and to facilitate access to available care services appropriate to their needs. A comprehensive assessment by an ACAS may result in the person's approval for entry into a residential aged care service or a referral to other community-based services, for example, those provided by the HACC program or a range of medical or health services. An approval or referral from an ACAS does not necessarily mean that the person will receive that care.

aged persons mental health services: mental health services for older people, generally co-located and operationally integrated with sub-acute facilities and ACAS. These services provide assessment, treatment, rehabilitation, continuing care and consultation, preferably in the community wherever possible. They use a system of case management that aims to ensure integrated care for the individual across community, inpatient and residential components of the service.

assessment: a decision-making method based on collecting, weighing and interpreting relevant information about the patient. Assessment is not an end in itself, but part of a process of delivering care and treatment. It is investigative, using professional and interpersonal skills to uncover relevant issues and to develop a care plan.

care coordination: coordination of the services required by the person so they are delivered in the most efficient and effective way to meet that individual's needs. Care coordination enables continuity of care, avoids duplication of services and ensures program boundaries do not hamper service providers in fulfilling the person's needs.

care pathways: an integrated care pathway determines locally agreed, multidisciplinary practice based on guidelines and evidence where available for the treatment of a specific patient/client group .

carer: someone (usually a family member) who provides support to children or adults who have a disability, mental illness, chronic condition or who are frail aged. Carers can be parents, partners, sons, daughters, brothers, sisters or friends of any age.

case management: the use of a case manager who helps the person and their carer work through care and related issues, as well as providing a single point of accountability for service provision. Case management involves care coordination.

clinical audit: the systematic and critical analysis of the quality of clinical care, including procedures for the diagnosis, treatment and care, the associated use of resources and the resulting outcome and quality of life for the patient.

clinical effectiveness: the application of the best available knowledge, derived from research, clinical expertise and patient preferences, to achieve optimum processes and outcomes of care for people.

clinical governance: the framework through which health organisations are accountable for continuously improving the quality of their services and safeguarding high standards of care by creating an environment in which excellence in clinical care will flourish.

clinical guidelines: systematically developed statements to assist practitioner and patient decisions about appropriate health care for specific clinical circumstances.

community: a person's normal residence, whether an independent house, a supported residential service or an aged residential facility.

comprehensive assessment of older people: a multidimensional process designed to assess an older person's functional ability, physical health, cognitive and mental health and socio-environmental situation.

department: Department of Human Services

Effective Discharge Strategy: the strategy was funded by the Department of Human Services for a period of five years from 1998–99 to improve discharge practices from public hospitals.

evidence–based practice: a process through which professionals use the best available evidence, integrated with professional expertise, to make decisions regarding the care of an individual. It requires practitioners to seek the best evidence from a variety of sources; critically appraise that evidence; decide what outcome is to be achieved; apply that evidence in professional practice; and evaluate the outcome. Consultation with the client is implicit in the process.

generic brief: provides guidelines for the planning and design of health and aged care facilities. Generic briefs are developed by the Department of Human Services.

Health Service: the acute and sub-acute campuses of a Health Service, as well as the additional programs that a Health Service provides in the community. The term 'Health Services' has been capitalised to differentiate it from general health care and ongoing community support services delivered by various providers in the community.

Home and Community Care (HACC): is a joint Australian Government/State Government program that provides services to support frail older people, younger people with disabilities and carers. HACC funds a range of basic support services that enable people to stay in the community and live as independently as possible, where otherwise they might have felt the only choice was to move into a residential facility. HACC services are provided by local governments, Royal District Nursing Service, community health services, public hospitals, community and voluntary organisations.

hospital: acute or sub-acute inpatient facilities.

Hospital in the Home (HITH): the provision of hospital care in the comfort of the person's own home. Patients are regarded as hospital inpatients and remain under the care of their treating doctor in the hospital.

interdisciplinary team: Interdisciplinary teams are defined by their approach to care in which team members from different disciplines collectively set goals and share resources and responsibilities. Interdisciplinary teams differ from multidisciplinary teams, from which they evolved; multidisciplinary teams create discipline specific care plans and implement these simultaneously without explicit regard to their interaction. Interdisciplinary teams also differ from transdisciplinary teams, in which each team member must be so familiar with the roles and responsibilities of other members that tasks and functions become, to some extent, interchangeable.

interim care: The care service provided to some people who have completed their acute or sub-acute treatment, had their needs assessed by the aged care assessment team and have been recommended for residential care. These people are described as 'awaiting long-term care options'.

older people-friendly hospitals: Health Services that promote an attitude of catering for the specific needs of older people and that have modified their environment and their staff expertise and mix to reflect this attitude.

ongoing community support services: are supportive care services such as assistance with personal care, meals and home maintenance. These services are provided in the person's home and are ongoing. Community support services are aimed at promoting independence and maintaining the person in the community.

post-acute care: the service provided to people after a hospital admission or emergency department presentation. It provides time-limited, individually tailored packages of supportive care to assist people to recuperate in the community.

primary care partnership (PCP): a voluntary alliance of primary care providers that work together to improve health and wellbeing in their local communities. There are 32 PCPs in Victoria.

sub-acute community-based therapy: sub-acute therapy delivered in the community exclusively; that is, in a patient's home (home-based care) and/or at a centre (centre-based care). This care type was previously referred to by the department as 'sub-acute ambulatory care'.

sub-acute care: goal-oriented, time-limited interventions, generally provided in a multidisciplinary environment to patients who require evaluation, treatment and management for post-acute or chronic conditions.

transdisciplinary assessment: an assessment tool that any trained member of a multidisciplinary team can use. Where the assessment flags specific issues, the appropriate professional will then provide specialist intervention.

Victorian patient satisfaction monitor: provides regular, ongoing monitoring and reporting of patient satisfaction with Victorian public hospitals in key areas of service delivery. There are currently 95 hospitals participating in Victoria.

Abbreviations

ACAS	Aged Care Assessment Services
ACE ward	Acute Care of the Elderly ward
CACPS	Community Aged Care Packages
CDAMS	Cognitive, Dementia and Memory Assessment Service
EACH	Extended Aged Care at Home (aged care package)
EQuIP	Evaluation and Quality Improvement Program
GP	General Practitioner
HACC	Home and Community Care (program)
HARP	Hospital Admission Risk Program
HART	Handicap Assessment Resource Tool
HITH	Hospital in the Home (program)
IDC	Indwelling catheter
NHT	Nursing Home-Type
PAC	Post Acute Care (program)
PCP	Primary Care Partnership
SCTT	Service Coordination Tool Templates
VQC	Victorian quality Council

Appendix A

Risk screening tool

A risk screening tool has been developed for the Department of Human Services by Thomas and Associates (1998). It is a four-question tool that is simple and quick to administer. It should be used as a minimum standard for risk screening.

The risk screening tool comprises the following elements:

- patient likely to have self-care problems
- patient lives alone and is over 70 years
- caring responsibilities for others
- patient used services before admission.

A positive response to any of these elements will flag the need for further assessment of the patient.

Carers Victoria

Appendix B
Remembering carers in discharge– some prompts

A carer is someone (usually a family member) who provides support to children or *adults who have a disability, mental illness chronic condition or who is frail aged. Carers can be parents, partners, sons, daughters, brothers, sisters or friends of any age.* ***Have you identified if the patient is a carer, has a family carer or will need one on discharge?***

If the patient is a carer,

have you discussed whether

☐the person they care for has adequate alternative care arrangements while the carer is in hospital

☐they have any concerns about how they will manage their care responsibilities on discharge and what impacts these may have on their recovery

☐additional supports may be required to support their caring responsibilities and recovery on discharge

If the patient has/will have a carer,

have you talked/discussed with the carer about

☐how confident and able they feel about their caring responsibilities after discharge?

☐their own health, emotional concerns or other issues that arise from or affect their caring (for example, poor health; work or other family commitments; grief reactions, stress or intimacy issues)

☐the supports they may need from other family members or services after discharge (for example, respite, carer education, assistance with household tasks, equipment)

☐discharge arrangements with the carer (date, time, transport) and given 24-hour notice about discharge

Have you provided the carer with

☐service information and made referrals (for example, regional carer service) to address carer support needs?

☐plain language information about the patient's illness, prognosis, treatments, medication and care management?

☐contact name and 24-hour contact number if they have worries post discharge?

☐a follow-up date when they will be contacted to see how they are managing and how services are working out?

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