Queensland Health

Rapid Results Program

Implementation toolkit for RACF support services (RaSS)

Queensland Government

Implementation guide for RACF support services (RaSS)

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This implementation toolkit was developed as a collaboration between Healthcare Improvement Unit and Metro South Health's CARE-PACT team, with particular acknowledgement of the contributions of the initial implementation team of Dr Ellen Burkett, Dawn Bandiera and Dr Raelene Donovan, and current CARE-PACT staff, with particular acknowledgement of Dr Terry Nash and Erin Cranitch.

The document or any component of it should be cited as:

Burkett E, Bandiera D, Donovan R, Cranitch E, Nash T, Ward T. Implementation tool-kit for \ Residential Aged Care Support Services (RaSS). CARE-PACT and Healthcare Improvement Unit, Queensland Health, Brisbane, 2019.

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RaSS service model overview

Residential aged care facility support services (RaSS) are Queensland Health (QH) funded services that provide some or all of the following acute care services to residents of residential aged care facilities (RACFs):

- Telephone triage (core) – telephone assessment of acute care needs and matching the care need to the most appropriate care delivery service
- Gerontic nursing assessment for RACF residents presenting to Emergency Department (ED) or admitted to hospital (core)
- Discharge planning, co-ordination and transitional communication for RACF residents presenting to ED or admitted to hospital, including for residents who have presented to and been discharged from ED after-hours (core)
- Follow-up of all RACF residents at 7 days (earlier if clinical need requires) to ensure fulfillment of referrals, resolution of care need
- ED substitutive care – acute care in the RACF environment as an alternative to ED transfer; the types of care able to be delivered will be determined by the scope of practice of individual RaSS staffing models (where resources allow); and
- Specialist consultative services via telehealth to RACF residents (where resources allow)

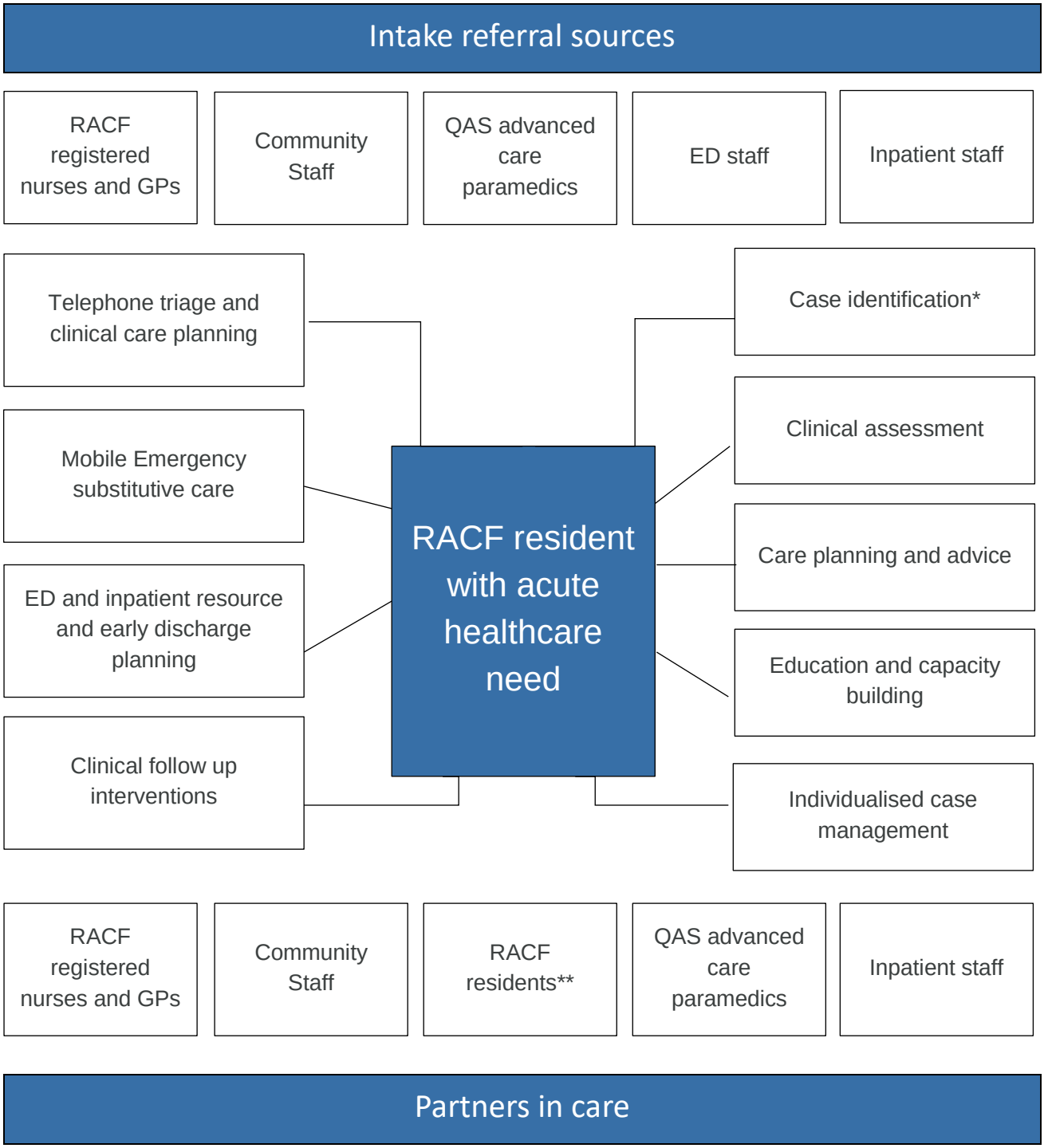
RaSS services aim to:

- Improve capacity of clinical staff across the care continuum to provide optimal care to residents of aged care facilities; and
- Optimise quality of care to residents of RACFs across the care continuum and
- Improve choice of care setting for RACF residents with acute healthcare needs, where these exceed the scope of the General Practitioner (GP) and RACF to manage independently of the hospital sector

Suggested reading:

Burkett E, Scott I. CARE-PACT: a new paradigm of care for acutely unwell residents in aged care facilities. AFP 2015. 44(4): 204 - 209.

Figure 1 RaSS service model representation [1]



*Intake referral sources supplemented by pull methodology (active screening of EDIS / FirstNet for RACF residents)

**Where RACF residents do not retain health decision making capacity, nominated substitute health decision makers are involved

Modified with permission from: Burkett E, Scott I. CARE-PACT: a new paradigm of care for acutely unwell residents in aged care facilities. AFP 2015. 44(4): 204-209.

How do we know it works?

The described model of RaSS care was implemented in the QH Metro South Hospital and Health Service (MSHHS) in 2014 as Comprehensive Aged Residents Emergency and Partners in Assessment, Care and Treatment (CARE-PACT), with the pilot program awarded Health Innovation Fund support. The program was externally evaluated by Deloittes' Access Economics with the following findings reported (nb. quantitative findings confirmed by before-after and interrupted time series methodology evaluations, pre-publication data) [2]:

Domain	Major Findings
Effectiveness	• Over the course of the pilot project phase, **an estimated 1,522 ED presentation were avoided**, and **an estimated 2,329 hospital admissions were avoided** • Over the course of the pilot project phase, the **median LOS of admitted patients from RACFs was reduced by 1 day** • Compliance with gerontic screening of RACF residents presenting to hospital (including cognition, delirium, skin integrity and falls risk) exceeded benchmarks for all components • The vast majority of stakeholders surveyed, including representatives from RACFs, general practice, and Hospital and Health Services (HHSs), agreed that the CARE-PACT project had achieved its objectives to a great or significant extent
Efficiency	• The reduction in ED presentations over the period was valued at $1.16 million • The reduction in hospital admissions was valued at $9.77 million • The reduction in inpatient length of stay (LOS) was valued at $3.83 million • Overall, the total value of savings over the project duration amounted to $17.1 million, realised in released capacity. This resulted in a ROI of 6.1
Appropriateness and Acceptability	• The majority of stakeholders were highly supportive (55 per cent) with a further 35% of respondents rating support between 7 and 9 on the 10-point scale • There were 2 respondents indicating low levels of support; these respondents were from RACFs, and perceived the service tended to assume a low level of capability and knowledge of RACF staff, when this is not always the case • In general, stakeholders were either extremely satisfied or very satisfied with the project overall, education and training provided, and support materials provided

Sustainability	• Project team and stakeholders largely agreed that the model in principle was sustainable, and aligned with the need to manage increasing demand • It was acknowledged that there were barriers to sustainability under current funding models that incentivise activity rather than demand management and hospital avoidance • Overall, project team members reported that CARE-PACT had built the skills and knowledge of key personnel to support sustainability and continue to improve clinical care of RACF residents • Stakeholders were largely in agreement, with 95 per cent agreeing they have a good understanding of the model, and 75 per cent agreeing that the project had built their skills and knowledge regarding care of RACF residents

Suggested reading:

Healthcare Improvement Unit, C.E.D., *Health Innovation Fund: Evaluation of Round 1 Project Final Outcome Evaluation Report - March 2017: Comprehensive Aged Residents Emergency and Partners in Assessment, Care and Treatment (CARE-PACT)*, Editor. 2017, Department of Health, Queensland Government Brisbane.

Critical success factors

Domain	Major findings	Major success factors
Effectiveness	ED presentation avoidance	• Resident-centred, collaborative decision making with consumer input in care planning • Skills-sharing approach across the care continuum • Strong stakeholder engagement strategies and marketing with a focus on specific needs of consumers, RACF clinical managers and GPs • Partnerships with aged care providers, local Primary Health Network (PHN), Queensland Ambulance Service (QAS), providers of services to aged care residents (HHS and private) • Single point of contact for RACF clinical staff with clear referral pathways (RACF & GP clinical guidelines) • Direct GP to ED consultant / geriatrician referral • Timely response of ED substitutive care with clear communication with substitute health decision maker, RACF clinical staff and GP • Follow-up of RACF residents arriving and discharged from ED after-hours to ensure care need fulfilled

Hospital admission avoidance	• ED presentation avoidance major success factors, plus the following: • ED staff education on gerontic assessment, management and alternatives to admission • ED-based gerontic nursing assessment team to have staff that are: o Senior, experienced clinical nurses with gerontic assessment expertise o Confident in advocating for patients in situations where dealing with senior medical staff o Able to work independently o In possession of excellent communication skills • RaSS staff orientation program and structured gerontic assessment tools • Broad inclusion criteria for referrals and pull system • Partnership with community palliative care services, community older persons mental health providers, dementia outreach and Hospital in the Home (HITH) services • 7-day follow-up of all residents discharged from service to ensure early identification of any potential risks for representation with a focus on iatrogenic complications, ensure fulfillment of referrals and advance care planning
Reduction in median LOS of admitted patients from RACFs	• Early anticipation and addressing of barriers to discharge from point of telephone triage or initial hospital contact assessment • Communication of RACF capacity / skill-mix to treating clinical team • Early liaison with GP, RACF and substitute health decision maker to confirm goals of care • Early gerontic nursing assessment to identify and care plan to reduce risk of iatrogenic complications, with a focus on cognition appropriate pain assessment, delirium screening, skin integrity check, falls risk minimisation • Performance of gerontic nursing assessments with ED nursing staff to build their capacity in gerontic assessment and to build their capacity across the 24-hour spectrum

	Compliance with gerontic screening of RACF residents presenting to hospital	• RaSS staff orientation program and structured gerontic assessment tools • Ability to measure and report effectiveness of interventions via Plan Do Study Act (PDSA) cycles – facilitated by clinical database that allowed creation of dashboards for reporting
Efficiency	Total value of savings over the project duration amounted to $17.1 million, realised in released capacity	• Lean staffing with an HHS-wide approach taken to leverage economies of scale • Leveraging of existing resources • Supportive HHS and hospital executives to enable smooth integration of service into existing HHS structures
Appropriateness and Acceptability	The majority of stakeholders were highly supportive	• Strong senior medical and nursing clinician leadership and executive support • Medical clinical governance • Resident-centred, collaborative decision making with consumer input in care planning • Skills-sharing approach across the care continuum • Understanding environmental and service constraints across the care continuum in making clinical recommendations

Sustainability	• Project team and stakeholders largely agreed that the model in principle was sustainable, and aligned with the need to manage increasing demand • It was acknowledged that there were barriers to sustainability under current funding models that incentivise activity rather than demand management and hospital avoidance.	Sustainability of staffing: • Ensuring high quality staff recruited with culture of quality and success • Ensure that staffing model is sustainable and able to be recruited to: what this looks like will be determined by local ability to attract and recruit staffing; CARE-PACT utilised an ED physician model with geriatrician and ED physician staffing supported by nurse practitioner, clinical nurse consultants and clinical nurses • Identify potential relieving staff during interview process and ensure they are offered opportunity to participate in the orientation of the team Sustainability of funding: • Ongoing engagement of executive • Reporting of results to executive and stakeholders • Understanding of activity-based funding (ABF) structures and elements of the project activity that are eligible (and are not eligible) for ABF; funding rules for ABF-eligible activities Sustainability of service delivery: • Services must be, and be identified by stakeholders as, safe, resident-centred and delivering ED-equivalent care • Investment in capacity building of staff across the care continuum to care for residents of RACF across the care continuum • Maximise service capacity by: o Utilisation of tele-health o Utilisation of nurse practitioners o Appropriately senior clinical triage o Ensuring triage of patients where appropriate to existing community services, rather than always to mobile ED substitutive care

RaSS model: getting started

** Please note that this resource will not discuss project management and implementation methodologies. It is recommended that a project manager and clinical lead, with a sound understanding of implementation science be recruited for project planning and implementation

Scoping: assessing demand and growth trends

The RaSS guideline should guide service development, however, local factors including existing resources and demand will influence the particular approach taken in each HHS. Critical to model development is a sound understanding of the following data:

Data domain	Data sources	Data analysis tips
RACF operational bed numbers and population profile of those in aged care	Aged Care Services (ACS) list available at: https://www.gen-agedcaredata.gov.au/Resources/Access-data?page=1&topic=9d0f6ebe-3d25-4eb6-a4fc-64c8898d172c Population profile of those in RACFs (by aged care planning region) at: https://www.gen-agedcaredata.gov.au/My-aged-care-region	Filter ACS list for: • Queensland • Residential bed type • Aged care planning regions that overlap with HHS (see below link for Aged care planning region maps) https://www.gen-agedcaredata.gov.au/Resources/Access-data/2018/May/Aged-Care-Planning-Region-Maps • Review each RACF and ensure postcode is one within HHS • Nb. You will need to review ACS lists over the last number of years to appreciate local growth trends
Older person population growth trends	https://www.dementia.org.au/sites/default/files/20100700_Nat_AE_Vol1CarePlaces2010-2050.pdf	Australian Institute of Health and Welfare (AIHW) also published more detailed population projections available at https://www.gen-agedcaredata.gov.au/Resources/Access-data/2014/August/Population-projections,-2012-(base)-to-2027-for-al

RACF ED presentations and growth trends	There is no current data item that allows accurate identification of RACF residents on QH databases; relying on address alone has a sensitivity of ~55 per cent; QAS data using geo-mapped address may have improved sensitivity but is limited by frequent co-location of independent living units with RACFs. There is additionally marked seasonal variation in RACF presentations – you will need to audit at least 1 year to understand the seasonal patterns in your HHS. Averaging presentations from peak seasonal high or low points will lead to either over- or under-estimation of potential effect.	This will require manual audit to achieve baseline data (or if you have advanced statistical support, a formal Logistic regression methodology is available – contact: ellen.burkett@health.qld.gov.au) Suggested manual audit methodology: 1. Data extract from EDIS or FirstNet of ED presentations 2. Filter by age to those aged 65 years and over (the vast majority of RACF residents are aged 65 years or over) 3. Filter by ambulance arrival (the vast majority of RACF residents present to ED via ambulance) 4. Screen remaining episodes with reference to the following identifiers: a. Address aligned to RACF address b. Keywords in presenting complaint field (RACF, nursing home, NH etc) c. Referral source = NH 5. When RACF residents are identified, consider the following for opportunities for ED substitutive care: a. Presenting complaints and discharge diagnosis b. Discharge status c. Advance care planning status (The Viewer)

Stakeholder mapping

Mapping of stakeholders is an important initial exercise that will assist in:

1. Determining optimal model of care in light of existing resources, gaps in care and potential for duplication of effort (or opportunity to leverage existing resource)
2. Development of a comprehensive stakeholder engagement plan

Services to consider are all those that may service RACF residents in their home environment and those that provide transition to or care in a hospital setting

Examples of services to consider include (nb. this is not a comprehensive list and requires localisation):

Care provision environment	Service type	Information additional to contact information and operational hours that will be useful
RACF	RACF clinical staff	Create a spreadsheet of all: • Facilities in the area that meet the RACF definition *(see glossary) • RACF clinical managers • RACF registered nurse staffing including competencies e.g. NIKI pump competencies, acknowledging that this may vary from day to day • RACF GPs • RACF resources available for allied health
	Community palliative care services	Some community palliative care services do not offer input for those residing in RACFs
	Community older persons mental health services	If no older person specific service does the adult community mental health team service RACF residents
	Dementia support services including local representatives of Dementia Support Australia services (including SBRT)	
Private community-based services	Private geriatricians and psycho-geriatricians prepared to see RACF residents	Whether in person review in RACF environment or telehealth services offered

	Private radiology services	Prepared to see RACF residents and whether they have ambulance access; are there any service providers offering mobile x-ray services to RACFs
	Private wound services	Prepared to see RACF residents and associated costs and modes of service delivery (in-person at RACF or telehealth is more consumer-friendly)
	Percutaneous endoscopic gastrostomy (PEG) companies	Education or trouble-shooting services provided
Hospital services	Gastrostomy services (radiology or gastroenterology)	Confirm which types of PEG tubes are stocked and determine whether the PEG providers provide RACF education / trouble-shooting service; confirm preferred method of replacing PEGs
	ED	Is there a nominated emergency specialist with an older person's portfolio
	Inpatient medical and geriatric teams	What is the acute flow for residents requiring admission in your facilities. Are they predominantly admitted under general medicine or geriatrics
	Older persons mental health team	Residents may receive care via a general psychiatry team where no older person specific team is available
	Orthopaedics	Is there a neck-of-femur fracture pathway? Is there an orthogeriatrician to link with
	Surgeons	Do the surgeons locally use any tools to predict mortality and surgical outcomes that can be introduced in conversations with families to inform decision making
	ED vs ward pharmacy services	Older-person specific pharmacist; hours of availability
	ED allied health services including social work and CHIP	Understand roles currently fulfilled and any gaps in service delivery or any potential for duplication of effort

Staffing models

There are three main models of staffing possible for RaSS services. These include:

1. ‘Dedicated RaSS Team’ – Team is recruited to provide RaSS services only.
2. ‘Dual Model of Care’ – Team recruited to provide both GEMITH / HITH and RaSS services
3. ‘ED or inpatient Shared Model’ – Staff that work in a hospital and also provide RaSS care within their scope of practice

The tested and therefore preferred model of care has a dedicated RaSS team that leveraged existing services to maximise gains for both residents and the health service. However, the optimal staffing model for each HHS should be localised based on the existing resources, available funding, RACF operational bed numbers, existing demand for acute hospital services by RACF residents and sustainability of the particular staffing model given local recruitment prospects.

The unit providing clinical governance will need to be localised dependent on existing health service structures, in order to maximise integration and leveraging of existing resources. The tested model of care has ED physician leadership with shared geriatrician and ED physician consultant staffing.

Existing health service structures may lend themselves better to integration of the services with a geriatrician or general physician-led service, however, it must be underlined that a key objective of RaSS services is to improve options for site of care delivery for RACF residents with acute care issues that would otherwise present to the ED. Any staffing model must prioritise the imperative to deliver clinical services at least equivalent to that which may be obtained should the resident present to the ED. Additional expertise that is required for any comprehensive staffing model is senior gerontic and ED nursing experience – gerontic nursing experience is prioritised for the ED and inpatient based arms of the service, whilst senior ED nursing expertise is required for the mobile ED substitutive care components of the service.

Staff roles and responsibilities

The below information outlines role descriptions for the staffing model of the established RaSS service, which leveraged economies of scale by a HHS-wide with four facilities, staffing model utilising: one clinical nurse rostered at each of four EDs to undertake gerontic ED and inpatient assessment and planning across seven days per week; clinical nurse consultants to each cover two EDs, to facilitate telephone triage, nursing leadership and training, telephone follow-up of those presenting to ED and discharged after-hours and telephone follow-up at 7-days; ED physician / geriatrician role to provide clinical governance to service and to attend clinical consultations on telephone triages and ED substitutive care service and consultative service to ED and inpatient teams; nurse practitioner and clinical nurse role to provide flexibility of resource deployment to meet clinical care need of resident.

It should be reiterated that the optimal staffing model for each HHS will require localisation based on:

1. Existing resources
2. Available funding
3. RACF operational bed numbers
4. Existing demand for acute hospital services by RACF residents, and

5. Sustainability of staffing model given local recruitment prospects – for example, nurse practitioners with training in acute geriatric emergency care are currently a rare resource; local recruitment prospects may result in, instead, recruitment and training of a nurse practitioner candidate or alternately consideration of registrar or additional consultant resources

The above may dictate that only a component of the staffing model be implemented, or an alternate approach be considered. If this is the case, it is pertinent to understand that health economic evaluation suggested that the greatest return on investment of the existing RaSS service was through reduction in hospital admissions and reduced inpatient LOS, so the preferred approach if not able to implement the full service would be to focus on the following elements (deemed above as core elements):

- Telephone triage to assess acute care needs and match the care need to the most appropriate care delivery service – this should be performed by a senior staff member such as a Clinical Nurse Consultant who is not involved in delivery of mobile ED substitutive care and should occur in consultation with the specialist ED or geriatrician
- Gerontic nursing assessment for RACF residents presenting to ED or admitted to hospital
- Discharge planning, co-ordination and transitional communication for RACF residents presenting to ED or admitted to hospital, including for residents who have presented to and been discharged from ED after-hours. It is critical that discharge communication occurs with the RACF and GP prior to and on same day as planned discharge.

Where resources allow, add ED substitutive care and specialist consultative services via telehealth to RACF residents.

It should be reinforced that:

1. All staff participating in mobile ED substitutive care should be credentialed to provide these services in accordance with HHS credentialing and scope of practice policies and procedures.
2. All staff involved in resident assessment or care in the RACF setting require federal police checks to be undertaken – this is a requirement of the Accountability Principles 2014 (the Accountability Principles) made pursuant to the Aged Care Act 1997 (the Act). Further information in relation to this can be found at: https://agedcare.health.gov.au/sites/default/files/documents/04_2017/police_certificate_guidelines_april_2017.pdf

ED physician (or geriatrician) specialist role (L24 – 27)

- Provide clinical leadership, supervision and clinical governance to the RaSS team and its patients
- **Clinical responsibilities**
  - Provide telephone or tele-health consultation to RACF staff, GPs or QAS paramedics for clinical assessment and care planning of aged care residents
  - Provide timely, high-quality and evidence-based clinical care to residents of RACFs in their own environments where the care need exceeds the scope of the GP or RACF staff to manage independently of the hospital sector
  - Ensure a high-level of effective communication with the residents' healthcare providers across the continuum of care
  - Demonstrates advance planning and co-ordination in the clinical management of patient care, identifying, anticipating and prioritising needs and working with the inter-disciplinary team in all settings to achieve patient and unit goals within required timeframes
- **Non-clinical responsibilities**
  - Stakeholder relationships:
    - Establish and foster relationships between RaSS and other relevant hospital and community-based services, GPs and RACFs to facilitate optimal transitions of care
    - Provide mentorship and skills sharing to empower RACF staff and GPs to autonomously undertake acute care of RACF residents in their own environment when clinically appropriate and in keeping with resident wishes
  - Safety and Quality:
    - Ensure RaSS policies, procedures and practices are consistent with contemporary best practice, with reference to Queensland and National Standards
    - Ensure that clinical services are of highest quality through the development, implementation, monitoring and review of quality improvement programs (encompassing clinical audit, Incident Monitoring, Root Cause Analysis)
    - Actively participates in the HHSs' Integrated Risk Management and Safety program
    - Demonstrates initiative aligned to ensuring the safest possible environment for patients and staff
    - Supervise, and ensure quality of, data collection and reporting to demonstrate RaSS activity and quality of care
  - Demonstrates efficient utilisation and management of resources as well as developing an awareness of budgetary issues in order to support hospital budgetary goals of cost containment and efficiency
  - Participate in peer review activities
  - Education:
    - Demonstrates a commitment to continuing professional development
    - Contributes to performance appraisal of junior staff
    - Promote awareness of available resources (community- and hospital-based) for meeting the acute healthcare needs of RACF residents

Clinical Nurse Consultant (NG07) role

- **Clinical responsibilities**
  - Provides clinical advice via telephone triage to the RACF clinicians supported by the Emergency Physician (or geriatrician):
    - Expert acute / emergency gerontic clinical assessment skills and care planning using advanced knowledge of contemporary treatments and outcomes to facilitate linkage to the most appropriate service to fulfil the resident's acute care need
    - Communicates closely with staff from hospitals, RACFs, GPs, residents, and community groups at the level of expert clinician to facilitate a right care, right place approach
    - Works to achieve high quality patient outcomes, reporting against specific key performance indicators
  - Undertakes:
    - Daily review of after-hours RACF ED presentations – admitted residents are referred to RaSS clinical nurse for gerontic nursing assessment, clinical nurse consultant follows up with a telephone call to RACF for all after-hours discharges to ensure that the residents' care need has been fulfilled, that continuity of medications has occurred (scripts, Emergency Department Discharge Medication Administration Record (EDDMAR) and medications available) – where there are gaps in care identified, GP or RaSS mobile ED assessment team is mobilised
    - A 7-day follow-up call for all RACF residents with a RaSS episode of care to assess:
      - The fulfillment of the residents' care need
      - Completion of any required tasks by RACF and GP, such as, advance care planning, outpatient department (OPD) referrals
      - Incidence of iatrogenic complications e.g. falls, delirium, death, representation to ED, readmission to hospital
- **Non-clinical responsibilities**
  - Promotes and demonstrates ideals of the RaSS model which facilitates professional communication, clinical skills sharing and effective utilisation of clinical resources to support the autonomous management of RACF residents in their familiar environment and to identify when the residents would be best served by hospital-based management
  - Direct supervisory responsibility for RaSS Clinical Nurses (ED and inpatient gerontic assessment and care planning team)
    - Provides clinical and professional support to all RaSS nurses, including rostering, professional performance development conversations, and education for the RaSS ED and inpatient gerontic clinical nurses
    - Demonstrates transformational leadership and team commitment through open communication and active participation in development and achievement of RaSS goals
  - Undertakes audit of all telephone triages for reporting to the monthly RaSS morbidity and mortality meeting:

- Leads and manages quality initiatives aligning to evidence-based best nursing practice and to local quality frameworks (i.e. Magnet and EQuIP), and to the National Safety and Quality Health Service Standards
- Participates in the development and achievement of departmental goals through effective use of all resources across the care continuum and a thorough understanding of the Business Planning Framework

Nurse Practitioner (NG08) role

- **Clinical responsibilities**
  Works within current Commonwealth, State and District regulations in relation to expanded authorities of the Nurse Practitioner Role
- Provides:
  - Rapid emergency and geriatric nursing assessment and acute care treatments for residents in the RACF setting
  - Advanced and extended patient-centred consultancy practice participating in direct and indirect patient care provision across the care continuum within the context of the multidisciplinary team
  - A high level of clinical proficiency in conducting advanced, comprehensive and holistic health assessments and a range of procedures, treatments and interventions that are evidence-based and informed by specialist knowledge within the specialties of emergency and geriatric nursing
  - Shared decision making with residents, their substitute health decision makers and the broader residents' healthcare team to achieve optimal outcomes by utilising best nursing practice and innovation
- **Non-clinical responsibilities**
  - Promotes and demonstrates ideals of the RaSS model which facilitates professional communication, clinical skills sharing and effective utilisation of clinical resources to support the autonomous management of RACF residents in their familiar environment and to identify when the residents would be best served by hospital-based management
  - Provides operational leadership of the RaSS mobile ED substitutive care team and direct supervision of the clinical nurses of this team:
    - Provides clinical and professional support to all RaSS nurses, including rostering, professional performance development conversations, and education for the RaSS mobile ED substitutive care clinical nurses
    - Demonstrates transformational leadership and strong team commitment through open, effective communication and active participation in the development and achievement of RaSS goals
    - Responsible for clinical consumable and medication management processes
  - Participates in the coordination, formulation and direction of policies and procedures relating to the provision of nursing care or specialty services
  - Provides clinical and professional support and education to RaSS and HHS senior nurses in gerontic assessment and management

- Undertakes monthly audit of RaSS mobile ED substitutive care episode of care to present at the monthly RaSS morbidity and mortality meeting
    - Promotes and participates in quality initiatives aligning to evidence-based best nursing practice and to local quality frameworks (ie Magnet and EQuIP), and to the National Safety and Quality Health Service Standards
- Participates in the development and achievement of departmental goals through effective use of all resources across the care continuum and a thorough understanding of the Business Planning Framework

Clinical Nurse (NG 06) role

- **Clinical responsibilities**
    - **ED and inpatient gerontic nursing assessment and care planning**
        - Accountable and responsible for own clinical practice. Reports directly to the RaSS clinical nurse consultant
        - Advanced gerontic screening, assessment and care of RACF residents via ED by coordinating care in collaboration with treating teams and community health services from ED to discharge – the central premise being to provide for continuity of care and discharge planning by identifying appropriate nursing interventions and referring to clinical support services where appropriate
    - **Mobile ED substitutive care**
        - Accountable and responsible for own clinical practice. Reports directly to the RaSS nurse practitioner or consultant
        - Demonstrates ability to work independently with advanced knowledge and skills in Emergency & Gerontic assessment and acute clinical care of residents in their own home environment
    - Able to practice in more complex situations integrating theory, practice and experience while providing support and direction to nursing staff and other members of the healthcare team and enhancing the quality of Geriatric nursing care
    - Demonstrates advanced planning and coordination in the clinical management of patient care, identifying, anticipating and prioritising needs and working with the interdisciplinary team in all settings to achieve patient and unit goals within required timeframes
    - Demonstrates advanced knowledge and skills in the speciality area of geriatric nursing
    - Demonstrates knowledge of relevant standards, clinical guidelines and advanced clinical practice. Acts as a resource for expert clinical care needs conducting formal and informal education and providing expert advice to all clinical staff, patients and their families
    - Demonstrates effective utilisation of resources to optimise unit services and patient outcomes in a rapidly changing environment
- **Non-clinical responsibilities**
    - Demonstrates leadership and provides clinical and professional support to RaSS senior nurses

- Demonstrates a strong team commitment through open, effective communication and active participation in the development and achievement of unit goals
- Promotes and participates in quality initiatives aligning to evidence-based best nursing practice and to local quality frameworks (ie Magnet and EQuIP), and to the National Safety and Quality Health Service Standards.
- Actively identifies areas for improvement; initiate monitoring and assess progress with the goal of achieving high quality patient outcomes and improving service delivery across the continuum of care
- Supports the collection of accurate, detailed and timely data

Administrative Officer (AO3) role

- Note for smaller RaSS services, this role may be able to be leveraged from the unit with which the RaSS sits – this will require agreement of this unit and its administrative managers
- Liaise with Information Technology unit in matters related to maintenance of RaSS clinical database
- Commitment to quality enhancement activity involving collection of clinical data. For example, preparation, analysis and report to RaSS clinical lead of:
  - Monthly activity reports
  - Quarterly quality reports
  - Collection of case-mix and cost data for all patients with service delivered by RaSS
- These reports require data from departmental databases and institutional systems including: ESM, HBCIS, EDIS / FirstNet
- Provide ongoing training for and liaison with medical, nursing and allied health staff in the clinical application of the database. This ensures high standards of data collection and facilitates the use of the database as a clinical tool to promote communication between health providers

Clinical governance

RaSS teams will most often cover multiple hospital sites within a HHS and have complex interactions with EDs, inpatient services, acute hospital substitutive services, community services and GPs.

Therefore, RaSS teams require clearly defined procedures to ensure that there are clear lines and processes around patient referral to services and that clinical governance is explicitly identified and understood.

It is recommended that:

1. Each RaSS service develop a clinical governance procedure that outlines where the clinical governances lies for each type of episode of care, with engagement of relevant HHS stakeholders in development of this procedure – an example procedure may be found on the QH intranet at: http://docs.sth.health.qld.gov.au/d/PR2015-53.pdf
2. At the completion of each RaSS episode of care, transitional communication contains implicit transfer of care of the resident to the continuity health care provider (i.e. GP)

Clinical documentation

Due to the likely cover of multiple hospital sites within a HHS and the complex interactions a broad range of stakeholders, RaSS teams require clearly defined procedures to ensure that there are clear guidelines for clinical documentation, in order to:

- To establish a consistent framework across the sites attended to by the RaSS for patient identification for the RaSS clinical database
- Outline the required clinical records & documentation for patient encounters within the RaSS
- Outline the procedure for booking of hospital avoidance activity in outpatient data management systems
- Outline the order of filing to occur for Clinical Records
- Promote real-time data entry and documentation of clinical activity to promote RaSS efficiency

It is recommended that each RaSS team develop a clinical records and documentation procedure, with engagement of relevant HHS stakeholders in development of this procedure. An example procedure can be viewed via the QH intranet at: http://docs.sth.health.qld.gov.au/d/PR2015-54.PDF

Communication

RaSS teams transcend multiple care transition boundaries and this requires a clearly defined communications procedure.

For services adopting a HHS-wide approach to leverage economies of scale, it is helpful to have a regular team update email to ensure that the team is apprised of:

- Team activity
- Quality indicator performance
- Safety or process updates

It is essential that all internal stakeholders have a clear understanding of the model of care and its driving aims to improve care of RACF residents across the care continuum. The messaging needs to be consistent across the care continuum. There is a risk that some stakeholders (internal and external) will erroneously view RaSS services as a barrier to access of RACF residents to acute hospital services – RaSS services aim to **improve** resident choice of care setting and facilitate timely access to acute services where this is clinically indicated and in keeping with resident choice.

It is also important in developing a communication plan to understand the complexity of the RACF environment and the pressures that RACF staff and GPs face – such an understanding is key to ensuring a relationship of mutual respect is able to be fostered. It is also helpful to consider each stakeholder group and during initial engagement confirm their preferred communication modality.

The following may be useful for sites to consider in their engagement of GPs:

1. GPs will often have allotted time to meet stakeholders – liaise with the GPs' practice manager (or where the GPs work solo, with the GP directly) to arrange an appointment
2. It is a marker of respect to GPs to have the most senior team member undertake engagement with them – this will generally be the RaSS consultant

3. It is important to establish with GPs:
    a. The primary goals of the RaSS to improve resident choice of care setting and improve quality of RACF resident care across the care continuum
    b. The ability of the GP to discuss or refer residents through a direct single phone call to the RaSS consultant
    c. That RaSS aims to strengthen the bond between GP and RACF through:
        i. Emphasis of clinical pathways that reinforce the role of the GP as central to RACF resident care
        ii. Requirement for GP consent prior to RaSS involvement in resident assessment or care at the RACF
    d. Challenges faced by the GP in relation to acute care of RACF residents across the care continuum, that the RaSS may be able to provide support with and in doing so, secure the engagement of the GP

The following may be useful to consider for engagement of RACFs:

1. Primary contact should initially be the clinical manager; schedule an appointment at a mutually agreed time at the RACF
2. It is a marker of respect to GPs to have the most senior team member participate in initial engagement with them – this will generally be the RaSS consultant
3. It is effective for the mobile ED assessment team and clinical nurse consultants who undertake telephone triage to be the primary ongoing engagement clinicians for RACF clinical managers
4. It is important to establish with the RACF clinical manager:
    a. The primary goals of the RaSS to improve resident choice of care setting and improve quality of RACF resident care across the care continuum
    b. Challenges faced by the RACF clinical staff that the RaSS may be able to provide support with and in doing so, secure engagement of the RACF clinical staff
    c. How the RaSS may assist RACFs in meeting the new Aged Care Quality Standards and how the resident-centred approach of the RaSS is supportive of resident choice
    d. An understanding of clinical resources that the RACF currently accesses e.g. GPs, after-hours GPs, allied health support

Marketing resources

A multimodal marketing plan will need to be developed. Take care to ensure your messaging is patient-centred and not systems-centred and consistent across the care continuum.

Consider use of a combination of the following to supplement face-to-face engagement strategies:

1. Pamphlets or fact-sheets for:
    a. Residents and families
    b. RACF clinicians
    c. GPs
2. Fact-sheets for internal stakeholders

3. Magnets / stickers to place near phones at nurses' stations of RACFs
4. Posters for hospital lifts and RACFs
5. Computer screen savers for internal and external stakeholders
6. Social media

You may be able to link with your local PHN and have them facilitate marketing with GPs and RACFs.

See appendix 2 for sample marketing tools

Relevant legislation

Each RaSS should familiarise themselves with the following Legislation and ensure compliance.

Aged Care related Acts from April 2017 are (please ensure that at the time of reading this document you check to determine whether this legislation remains current):

- *Aged Care Act 1997*
- Accountability principles 2014 pursuant to the Aged Care Act 1997.
- *Aged Care (Transitional Provisions) Act 1997*
- *Aged Care (Accommodation Payment Security) Act 2006*
- *Aged Care (Accommodation Payment Security) Levy Act 2006*
- *Australian Aged Care Quality Agency Act 2013*
- *Australian Aged Care Quality Agency (Transitional Provisions) Act 2013*
- *Aged Care Amendment (Red Tape Reduction in Places Management) Act 2016*

Queensland legislation relevant to substitute or emergency decision making includes:

- *Guardianship and Administration Act 2000*

Legislation governing medication management

- *Health Act 1937*
- *Health (Drugs and Poisons) Regulation 1996*

Relevant Queensland Health policies, procedures and guidelines

- Advance care planning clinical guidelines https://www.health.qld.gov.au/__data/assets/pdf_file/0037/688618/acp-guidelines.pdf
- Credentialing and defining the scope of clinical practice https://www.health.qld.gov.au/__data/assets/pdf_file/0032/670973/qh-pol-390-23.10.17.pdf
- HITH guideline https://www.health.qld.gov.au/__data/assets/pdf_file/0016/147400/qh-gdl-379.pdf
- IMAR / EDDMAR documents https://qheps.health.qld.gov.au/medicines/medication-safety/imar-eddmar

- Portable and Attractive assets https://www.health.qld.gov.au/__data/assets/pdf_file/0034/395818/qh-pol-417.pdf
- Queensland Health Risk management policy, standards and guidelines https://qheps.health.qld.gov.au/csd/business/risk-and-audit-services/risk-services/risk-advisory-and-training-services#RMF

Staff safety

RaSS team members, where services include a mobile ED substitutive care team and also where face-to-face community stakeholder engagement is undertaken, will be travelling to off-site locations.

This involves a number of risks that can be mitigated by:

1. Ensuring that all those who are travelling to off-site locations undertake the appropriate QH driver training
2. Travel occurs in a QH approved vehicle with appropriate insurance in place
3. The clinical lead knows where staff are travelling to at any time
4. For delivery of clinical service, ensure that a minimum of two staff are present – there are times when staff will encounter aggressive residents and two staff reduces risk of unnoticed assault
5. All staff should undertake appropriate training in relation to de-escalation and management of aggressive behaviours
6. For occupational health and safety, equipment required by the mobile ED substitutive care team should:
    - Be transported in a suitable trolley that is collapsible and easily able to be transferred into the vehicle
    - The vehicle should have no rear boot lip, minimising lifting

It is suggested that all RaSS teams develop a guideline or work-instruction encompassing processes to optimise staff safety

Orientation resources

A formal orientation program at service inception should be developed. This will need to be localised to the specific model of care implemented. However, common areas to cover should include:

1. Orientation to the model of care
2. Clinical governance structures
3. Professional and operational reporting structures
4. Stakeholders and stakeholder engagement processes
5. Communication procedures
6. Documentation procedures
7. Key performance indicators and how to optimise outcomes

8. Gerontic assessment and care planning
9. Risks and risk management including project, clinical and staff risks

An orientation manual should be developed as a resource for clinical staff to encompass the above and also including links to relevant hospital and departmental procedures and contact numbers for relevant stakeholders.

Capital purchases

Guiding Principles

Optimal capital purchases / initial outlays will be determined by:

1. Particulars of the components of a RaSS model of care that sites are planning to implement. All sites will need equipment to facilitate the following components of a RaSS service:
    a. Telephone triage
    b. ED / inpatient gerontic nursing assessment and discharge planning
    c. RACF education
    d. Telephone follow-up

    Those sites with sufficient RACF operational beds to justify this, will benefit from the addition of a mobile ED substitutive care team.
2. Staffing model that sites determine their allocated funding will support – this will influence:
    a. Number of phones / computers required
    b. The case-mix of types of residents that will be able to be seen safely in the RACF environment by an ED-substitutive care service (and therefore the equipment needed to support this service delivery)
3. Existing equipment within the HHS that is able to reasonably and sustainably leveraged for the purposes of the RaSS service as it is otherwise not in use e.g. office supplies (chairs, tables etc), existing fleet vehicles
4. For mobile ED substitutive care service, for all equipment purchases consider any relevant occupational health and safety requirements – where able, purchase small and easily transportable options
5. Review the case-mix that your team is likely to see (informed by your planned staffing model and by your RACF ED presentations currently that you plan to encompass in your ED substitutive care model)
6. It is also suggested that you review the capital / equipment needs that may be required for any down-stream services you may be referring to as this patient cohorts needs may not be well catered for by their existing equipment e.g. HITH

Capital expenditure items or initial outlays to consider

RaSS model component	Capital item	Additional considerations / comments
Mobile ED substitutive care	Vehicle	Consider potential use of fleet vehicles for education etc. – however, mobile ED substitutive care team will need rapid and regular access to a vehicle; for occupational health and safety purposes, ensure vehicle boot has no lip to allow easy deposition and removal of equipment; ensure that navigational equipment considered to improve trip planning and efficiency
	Life-pak or alternate mobile monitoring device	Ensure model allows following functions: • Pulse oximetry • Blood pressure measurement • Telemetry • 12-lead ECG generation and printing • Consider requirement for access to defibrillator / pacing functions
	Tympanic thermometer	
	Blood glucose machine	
	iSTAT analyser with downloader recharger kit; rechargeable power pack; ceramic cartridge	Ensure particular model allows the following functions: • Blood gas analysis • Chemistry analysis • INR • TnI (optional) Note: liaise with local pathology services to determine whether an electronic simulator will be required
	Small fridge and esky	This will allow safe storage and transport of iSTAT cartridges and drugs requiring refrigeration; temperature monitoring device will be required to ensure optimal storage temperature is achieved
	NIKI pump syringe pump/s	
	Portable infusion devices	

	Portable doppler machine	Optimal if arterial waveform displayed and / or printable
	Portable bladder scanner	
	Drug and equipment bag/s	A variety of drug bags are available – review the case-mix, staffing model to determine likely drugs to be required prior to finalising a drug bag choice e.g. NEANN intensive care drug kit
	Collapsible trolley with wheels	e.g. Clax cart
	Plastic storage boxes with handles	
	S8 drug storage cupboard	This may be able to be leveraged from existing hospital resources
	Lockable storage cabinet to allow safe storage of clinical consumables and medications	This may be able to be leveraged from existing hospital resources
All service components – clinical	Fiddle blankets and IDC decoy distraction aprons	Ensure that any chosen product does not represent any safety risks
	Sensory stimulation / distraction devices for cognitively impaired – these may reduce agitation or need for sedation	https://thesensorystore.com.au or https://dementiashop.com.au/shop/ or https://www.dementia.org.au/files/TAS/documents/Sensory-Merchandise-Catalogue-May-2017.pdf Consider infection control requirements in purchases

	Pocket talkers / voice amplifiers including disposable ear covers	Consider infection control requirements in purchases
ED-based gerontic assessment	Consider ED environment and any particular gerontic-friendly modifications that may improve ED experience for older persons	e.g. Way-finding Orientation markers e.g. clocks Large soft reclining chair/s (consider infection control requirements in purchases)
All service components – non-clinical	Printer with fax capability	
	Desk / desk space	
	Office chairs	
	Telephones	Consider advantages and disadvantages of desk-top, DECT versus mobile phones; ED substitutive care services will need mobile phones; these may also be advantageous for telephone triage
	Computers	Consider advantages and disadvantages of desk-top versus mobile devices versus tablets – ensure any operational system is able to be utilised well on tablets if progressing with this option; ensure that for mobile ED substitutive care team any tablet or mobile devices purchased are able to facilitate wireless internet access; depending on location and mobile network services, this may require purchase of a device to boost the mobile network signal; remote access to wireless network will facilitate ability to link in to QH servers to enable documentation on the road and sourcing of medical records on the road

Marketing and education resources	RACF clinical pathways	Consider funding a colour print-run of the CEQ handbook "Management of acute care needs of RACF residents" – consider number of RACFs, number of clinical units within the RACFs, account for potential losses; also consider additionally copies for GPs servicing the RACFs; choose printing with high quality thick paper and a cover that is wipeable and robust.
	Stakeholder engagement pamphlets	Design and print pamphlets for: Consumers – consider whether you will require translation to any particular non-English languages e.g. does your HHS have culturally and linguistically diverse (CALD) RACFs that cater to a specific cultural group/s RACF clinical staff & GPs Hospital stakeholders
	RaSS team education	Geriatric emergency medicine texts Geriatric texts Palliative care texts

Clinical consumables

Clinical consumables distinct from those of the ED or inpatient areas are only relevant for those RaSS teams that encompass a mobile emergency substitutive care team.

The clinical consumables listed are only provided as a guide. Clinical consumables required will be dependent on the staffing model, skill mix of the service and case-mix of RACF ED presentations that are considered suitable for ED substitutive care.

Clinical consumable domain	Subgroup	Clinical consumable item
Airway / breathing	Oxygen delivery	Nasal prongs
		Oxygen tubing
		Oxygen tubing connector
		Hudson mask
		15L Non-rebreather mask
		Bag valve mask
	Nebuliser	Nebuliser bowl
		Nebuliser Sidestream kit
	Airway adjuncts	Guedels oropharyngeal airway (sizes 3,4 and 5)

		Nasopharyngeal airways (sizes 6,7 and 8)
	Suction	Yankauer suction catheter
		Y-suction catheter (12-FG)
		Suction tubing
		Hand-operated suction pump
Circulation	IV cannulation	Autoguard IV cannulas (18G to 22G)
		IV starter kit
		Bungs
		Tegaderm IV advanced
		Tourniquet
		IV pressure pads
		Blue injection trays
		Alcohol wipes
		Chlorhexidine swabs
	IV fluid administration	Giving set (gravity)
		Burette
	Syringes and needles	Syringes: catheter tip 50 mls
		Syringes: 3, 5, 10, 20 mls
		3mL syringe with retractable needle
		1mL insulin syringe with retractable needle
		Sharp needles (21G, 23G)
		Blunt fill needles
		Solu IV
		BSL lancets
Monitoring / assessment consumables	Oxygenation assessment	spO2 finger probe
	BP measurement	Manual sphygmomanometer
		Stethoscope
		BP cable
		BP cuff (range of sizes small to large)
	ECG acquisition	ECG monitoring leads (12-lead ECG capable)

		ECG foam dots
		Defibrillation pads
		Defibrillator
		Test Load Device for LifePak
		LifePak paper
	General assessment	Tympanic Thermometer
		Tympanic Probe Covers
		Tongue Depressors
		Tendon hammer
		BSL monitor and lancets
		iSTAT temperature indicators
Wound management	Wound preparation / debridement	Basic dressing packs
		Sterile scissors
		Forceps (dressing, 12cm)
		Scalpel
		Barrier wipes
		Skin marker
		Razor
		Adhesive remover
	Wound edge apposition	Sterile suture pack
		Suture materials (as per preference of lead clinician)
		Steristrips
		Dermabond
		Suture cutter
		Sterile gauze
		Staple gun
		Staple remover
		Mepilex
		Mepilex border
		Mepilex Ag
		Mepilex border Ag

	Meglisorb Ag
	Mepitel
	Aquacel extra
	Aquacel Ag
	Acticoat
	Relevo
	Inadine
	Iodasorb
	Combines
	Bandages – crepe brown
	Bandages – conforming
	Triangular bandage
	Tubifast large
	Tubigrip (sizes E,F and G)
	Opsite
IDC / continence	Catheter pack
	Lignocaine gel 2% syringe
	Foley catheters (14, 16 and 18 Fg)
	Stat lock
	Drainage bag 2L
	Drainage bag leg (with straps)
Investigations	Ultrasound gel
	iSTAT & cartridges
	Urine specimen containers
	Urine specimen syringes
	Blood tubes (Purple, red, blue, pink, blood cultures)
	ABG syringes
	Bacterial swab
	Pathology bags
	Biopsy punch (2,3 and 4mm)
	Gloves (S, M, L)

Personal protective equipment	Sterile Gloves (6,7,8)
	Plastic aprons
	Blueys
	N-95 masks
	Goggles
	Emesis bags
	Sharps container
	Detergent wipes (e.g. Tuffies)
	Alcohol wipes (large)
	Sharps container (1.4L)

Medications and medication management

Pharmacy supplies distinct from those of the ED or inpatient areas are only relevant for those RaSS teams that encompass a mobile emergency substitutive care team.

The medications listed are only provided as a guide. Medications required will be dependent on the staffing model, skill mix of the service and case-mix of RACF ED presentations that will be considered suitable for ED substitutive care by each RaSS team. Where nurse practitioners are involved in delivery of ED mobile assessment services, it should be ensured that they are endorsed to prescribe the relevant medications.

Drug name generic, strength	Formulation
Adrenaline, 1mg/1ml, 1mL	Injection
Amiodarone,150mg/3ml	Injection
Amoxycillin - Clavulanic Acid, 875mg-125mg	Tablet
Amoxycillin, 500mg	Tablet
Ampicillin, 1g	Injection
Aspirin Soluble, 300mg	Tablet
Atropine, 0.6mg/ml, 1mL	Injection
Azithromycin, 500mg	Injection
Benztropine, 2mg/2ml	Injection
Benzylpenicillin, 1.2g	Injection
Bupivacaine, 0.5% 20mL	Injection
Calcium Gluconate, 10% 10mL	Injection
Cefazolin, 1g	Injection
Ceftriaxone, 1g	Injection

Cephalexin, 500mg	Capsule
Chloramphenicol topical eye ointment	Eye
Clindamycin, 150mg 100mg	Capsule
Dextrose 10% 500mls	IVF
Doxycycline, 100mg	Tablet
Droperidol, 10mg/2ml	Injection
Enoxaparin, 100mg/1mL Prefilled Syringe	Injection
Enoxaparin, 60mg/1mL Prefilled Syringe	Injection
Famciclovir, 250mg	Tablet
Flucloxacillin, 1g	Injection
Flucloxacillin, 500mg	Capsule
Frusemide, 20mg/2ml	Injection
Gentamicin, 80mg/2ml	Injection
Glucose, 50% 50ml	Injection
Glyceryl Trinitrate, 0.6mg S/L	Tablet
Hydrocortisone, 100mg	Injection
Hyoscine Butylbromide 20mg/1ml	Injection
Ipratropium, 500mcg/ml	Nebule
Lignocaine/Adrenaline, 1% 5mL	Injection
Lignocaine, 1% 5mL	Injection
Loratadine, 10mg	Tablet
Metronidazole, 500mg/100mls	Injection
Metoclopramide, 10mg/2ml	Injection
Microlax Enema 5ml	Rectal
Naloxone, 400mcg/1ml	Injection
Olanzapine, 5mg	Wafer
Ondansetron, 4mg	Wafer
Ondansetron, 8mg/4ml	Injection
Paracetamol, 500mg	Supp
Phytomenadione, 10mg/ml	O/IV
Prednisolone, 25mg	Tablet
Prednisolone, 25mg	Tablet

Probenecid, 500mg	Tablet
Prochlorperazine, 12.5mg/ml	Injection
Risperidone, 2mg	Tablet (quicklet)
Roxyithromycin, 300mg	Tablet
Salbutamol, 5mg/2.5ml	Nebule
Sodium Chloride, 0.9% 10ml	Injection
Sodium Chloride, 0.9% 100ml	Injection
Sodium Chloride, 0.9% 250ml	Injection
Sodium Chloride, 0.9% 500ml	Injection
Sodium Chloride, 0.9% 1L	Injection
Trimethoprim, 300mg	Tablet
Water For Injection, 10ml	Injection

As the RaSS team will be travelling off-site with the above medications, it is recommended that each RaSS team develop a procedure that outlines relevant aspects of medication management, with particular emphasis on schedule 8 medication management and appropriate medication storage. An example procedure is found at:
http://paweb.sth.health.qld.gov.au/sqrm/qiu/documents/procedures/02290.pdf

Additionally, there is a requirement for a procedure outlining management of anaphylaxis should this occur in the RACF environment as a result of drugs administered by the mobile ED assessment team. An example procedure is found at:

http://paweb.sth.health.qld.gov.au/sqrm/qiu/documents/procedures/02289.pdf

Continuity of medications is identified as a critical aspect of transitions of care for residents of aged care facilities . Additionally, there will be a requirement for a hospital-wide education process for pharmacists on generation of Interim Medication Administration Record (IMAR) and for ED clinicians for generation of EDDMAR, in order to optimise continuity of medications. Template marketing and explanatory material may be found at:

https://qheps.health.qld.gov.au/medicines/medication-safety/imar-eddmar

Quality improvement

National standards alignment

RaSS services should aim to ensure the following alignment to National Standards: Standard	RaSS alignment
1 – Governance for safety & quality in health service organisations	Implementation of a governance system with specific policies and procedures to ensure safe management of patients in an RACF setting – see links to example RaSS procedures
	Clear accountabilities to individual staff members and the service as a whole – see links to example RaSS clinical governance procedure
	Competency-based training and orientation packages for new and relieving staff
	RaSS risk register is regularly maintained with linked actions to minimise risks to patient safety
	Regular audits, use of RISKMAN clinical incident reporting tool, regular reporting to Quality & Safety committee
	In collaboration with partners, RaSS has implemented a suite of acute care pathways for management of acute health care needs of RACF residents for use by GP, RACF and the RaSS, thus promoting standardised care across the community-hospital interface
	RaSS clinical pathway suite includes pathways (with training modules) on identification of a deteriorating resident, facilitating earlier detection of an unwell RACF residents by GPs & RACF staff
	RaSS uses the integrated patient clinical record to document assessments across the care continuum, facilitated by use of an electronic clinical database that allows clinical notes to be entered in real-time, no matter where in the care-continuum the assessment occurs; See example medical records management procedure
2 – Partnering with consumers	RaSS has included a consumer representative on the steering committee – the consumer gives direct input into strategic decisions and is consulted regarding all patient information brochures provided by the RaSS

	RaSS models of care have been designed with consumer and carer input to better meet the needs of this frail patient group, and to provide advocacy for this often-disenfranchised group
3 – Preventing and controlling healthcare associated infections	The RaSS ED substitutive care mobile assessment team undertakes a risk screen for infectious causes prior to deployment; standard precautions are used as a matter of course; the core stock of the team includes personal protective equipment and sterile equipment to ensure ability to undertake all procedures in a manner that minimises risk of infection to both staff and patient
	The RaSS supports antibiotic stewardship within the RACF setting by providing evidence-based guidelines to assist in diagnosis of common complaints where antibiotics may be required – these guidelines have been largely aligned to the national Therapeutic Guidelines for antibiotics; additionally, where acute hospital substitutive care is clinically appropriate, the infectious diseases team is involved to ensure most appropriate antibiotic choices are made
4 – Medication safety	The RaSS supports medication reconciliation by reminding facilities to provide an up to date medication list and list of allergies as part of transfer documentation for those patients transferred to ED – this is part of the check-list for transfer, the RACF-ED communication tool initiative (yellow-envelope or electronic equivalent) and the telephone triage process; additionally the RaSS directly refers to pharmacists for generation of an IMAR where discharge medications are required and supports generation of EDDMAR for eligible ED discharges to improve medication continuity.
5 – Comprehensive care standard	• The RaSS provides a telephone triage service that allows RACFs / GPs / QAS to ring and consult RaSS CNCs / NPs / ED / Geriatrician specialists - the patients' care needs are assessed and matched to the most appropriate service to fulfil these needs; decision making regards where these needs are fulfilled also involves the resident / their substitute health decision maker and GP • RaSS facilitates care for persons of diverse cultural backgrounds by ensuring cultural and spiritual needs are assessed and addressed whether the patient is seen in the hospital or RACF setting • RaSS facilitates promotion of influenza vaccination programs in RACFs and of RaSS staff The RaSS provides the following: 1. Screening for gerontic syndromes and risks including cognitive impairment, delirium, skin integrity, falls, cognition appropriate pain assessment; baseline condition is

	documented to facilitate identification of changes from baseline 2. The above screening contributes to a comprehensive gerontic care plan, appropriate referrals and RiskMan / alert reporting 3. Support to identify / develop advance care plans and ensure that goals of care are encompassed in shared decision making with residents or their substitute decision makers 4. Structured gerontic assessment and care planning tool that is recorded on a clinical database allowing for SQL reporting and dashboarding of performance against processes of comprehensive screening, assessment and care-planning 5. Alerts for risks (and above comprehensive gerontic assessment and care plan) are entered into the unified health record and communicated to the treating team/s across the are continuum 6. Ongoing review, recurrent screening where indicated and modification of the comprehensive care across the resident's hospital journey and then follow-up at 7 days post-discharge to ensure resolution of the care need and to screen for iatrogenic complications associated with hospitalisation that may contribute to further resident risk / require modification of care plan; ensuring fulfillment of referrals and providing information to the RaSS team regarding opportunities for improved care 7. On discharge, collaborative plan is developed with the RACF, allied health, resident and family regarding a nursing care plan to provide ongoing risk minimisation in the facility
6 – Communicating for safety	The RaSS streamlines care and referrals to acute substitutive care services, thereby limiting the need for duplication of assessment and hand-overs with their associated risks; patient, family and primary care providers are included as partners in the assessment process. All clinical hand-over processes of the RaSS utilise an ISBAR format
8 – Recognising and Responding to Clinical Deterioration in Acute Health Care	RaSS strengthens compliances with standard by: • Use of patient outcome information for quality review • Provision of a responsive assessment of patients with direct collaboration with primary care providers • Provision of guideline-based treatment • Guidelines for escalation or notification of clinical concerns

	• Supporting RACFs to utilise an early warning, colour-coded observation guide with pre-defined mandatory reporting guidelines • A referral pathway which clearly identifies which patients are appropriate for the RaSS and which require direct transfer to an ED

Support to RACFs for Aged Care Quality Standards

New Aged Care Quality Standards commence in July 2019, which RACFs will report against. Each RaSS should familiarise themselves with these standards and understand how their service aligns and could support RACFs to meet these – this will be assistive in securing engagement of RACFs.

Further information about the Aged Care Quality Standards is available at: https://www.agedcarequality.gov.au/providers/standards

Quality improvement measures

Data and key performance indicators (KPIs) are to be monitored, analysed and reported via local HHS processes. Service evaluation is important for the ongoing monitoring and evaluation of service level data to ensure KPIs are met.

- Measures for evaluation of services include the following levels of measurement:
  - Tier 1: Reporting measures (mandatory)
  - Tier 2: Service measures (desirable)
  - Tier 3: Patient measures (desirable)

Donabedian domain	Measure (tier)	Numerator / denominator	Data items	Data source
Structure	The RaSS has structured gerontic assessment tools for RACF resident comprehensive	N/A	Structured gerontic assessment tools available	Structural audit

	assessment (2)			
Process	Proportion of RACF residents where ED providers accurately identify the residential setting (2) - Nb. this QI will only be applicable on implementation of the residential setting data item in FirstNet	Number of RACF residents where ED providers accurately identify the residential setting / Number of RACF residents presenting to ED	RACF residents presenting to ED with an episode of care documented in the RaSS clinical database	RaSS clinical database
			Residential setting identified by ED	FirstNet or EDIS
	Proportion of RACF residents where RaSS providers identify the contact details and level of authority of nominated substitute health decision maker (3)	Number of RACF residents where RaSS providers identify the contact details and level of authority of nominated substitute health decision maker / Number of RACF residents with an RaSS episode of care	RACF residents with an RaSS episode of care	RaSS clinical database
			Contact details of nominated substitute health decision maker	
			Level of authority of nominated substitute health decision maker	
	Proportion of RACF residents where acute care providers document goals of care (acute resuscitation plan or advance care plan) (1)	Number of RACF residents where acute care providers document goals of care / Number of RACF residents with an ED episode of care	RACF residents presenting to ED with an episode of care documented in the RaSS clinical database	RaSS clinical database
			ARP or ACP documented and referred to within the episode of care	RaSS clinical database and The Viewer data
	Proportion of RACF residents where acute care providers document a cognition appropriate pain	Number of RACF residents where acute care providers document a cognition appropriate pain assessment / Number	RACF residents presenting to ED with an episode of care documented in the RaSS	RaSS clinical database

	assessment (3)	of RACF residents with an ED episode of care	clinical database	
			Cognition appropriate pain assessment	
	Proportion of RACF residents who receive a skin integrity assessment during the ED episode of care (3)	Number of RACF residents who receive a skin integrity assessment during the ED episode of care / Number of RACF residents with an ED episode of care	RACF residents presenting to ED with an episode of care documented in the RaSS clinical database	RaSS clinical database
			Skin integrity assessment	
	Proportion of RACF residents who receive a delirium screen during the ED episode of care (3)	Number of RACF residents who receive a delirium screen during the ED episode of care / Number of RACF residents with an ED episode of care	Number of RACF residents who receive a delirium screen during the ED episode of care	Delirium screen
	Median ED LOS for RACF residents with an ED episode discharge status of admitted (1)	N/A	ED arrival time	FirstNet / EDIS
			ED physical departure time	
			Disposition destination (to allow exclusion of SSU admissions)	
			RACF residents	RaSS clinical database
	Proportion of ED substitutive care episodes associated with a subsequent ED presentation in the following 7 days (1)	Number of ED substitutive care episode in RACF residents who have an ED presentation in the 7 days following the end of the episode of care / Number of ED substitutive care episode in RACF residents	ED substitutive care episodes	RaSS clinical database
			ED representations within 7 days	

	Median time from telephone triage to mobile ED substitutive care episode (1)	N/A	Time of telephone triage Time of commencement of mobile ED substitutive care episode	RaSS clinical database
Outcome	Median hospital inpatient LOS for RACF residents (1)	N/A	Hospital inpatient LOS	HBCIS
			RACF residents with a RaSS episode of care	RaSS clinical database
	ED presentations for RACF residents per RACF operational bed (calculated for HHS) (1)	Number of RACF residents with an ED episode of care / Number of operational RACF beds in HHS	RACF residents presenting to ED with an episode of care documented in the RaSS clinical database	RaSS clinical database
			Operational RACF beds in HHS	Aged care services list

Morbidity and mortality meetings

Morbidity and mortality meetings for the RaSS team should be held on a monthly basis to review 7-day follow-up morbidity and mortality for all residents with particular emphasis on those residents who were avoided from ED presentation via telephone triage and / or mobile ED assessment.

All cases where there are any of the following should be reviewed:

1. Death within 7 days of discharge from service *(or up to 28 days where this is notified by the RACF providers) – a significant proportion of these will be in palliative patients and be expected deaths, however, review will need to actively identify this
2. Morbidity including:
    a. ED representation within 7 days of discharge from service
    b. Hospital readmission within 7 days of discharge from service
    c. Falls, pressure injuries or delirium within 7 days of discharge from service

Service dashboards

RaSS documentation systems should facilitate regular reporting to allow development of service dashboards to reflect RaSS team activity and quality performance.

Appendices

Appendix 1: RaSS Gerontic assessment templates

Telephone triage template

Queensland Government Insert HHS name Insert HHS RaSS name **Telephone Triage**	Facility: URN: Family name: Given name (s): Address: Date of birth: Sex: ☐ M ☐ F ☐ I

Situation: *[insert free text]*

Background: *[insert free text]*

Assessment: *[insert free text]*

Recommendation: *[insert free text]*

Electronic signature:

Created by Created date Last modified by Last modified date

Caller details Name of caller:

Designation of caller: ☐RACF clinician ☐GP ☐QAS paramedic ☐Hospital clinician ☐Other - specify

Contact number of caller:

Date/time of call: DD/MM/YYYY HH:MM

Vital signs Date and time recorded:

Temperature:	°C	Responsiveness (AVPU or GCS):	
Pulse rate:	bpm	BGL:	mmol/L
Blood pressure:	mmHg	Pain: Numerical rating scale (N/10)	
Respiratory rate:	bpm	Pain: PAINAD (N/10)	
Oxygen saturations:	%		

Queensland Government Insert HHS name Insert HHS RaSS name **Telephone Triage**	Facility: URN: Family name: Given name (s): Address: Date of birth: Sex: ☐ M ☐ F ☐ I

Comorbidities

☐ AIDS / HIV	☐ Anaemia	☐ Anticoagulated	☐ Any malignancy, including leukaemia and lymphoma	☐ Asthma
☐ Atrial fibrillation	☐ Cerebrovascular disease	☐ Chronic pulmonary disease	☐ Congestive cardiac failure	☐ Dementia
☐ Depression	☐ Diabetes with chronic complications	☐ Diabetes without chronic complications	☐ Hemiplegia or paraplegia	☐Hypertension
☐ Hyperlipidemia / dyslipidemia	☐ Hypothyroidism	☐ Ischemic heart disease	☐ Liver disease – mild	☐ Liver disease – moderate or severe
☐ Metastatic solid tumour	☐ Myocardial infarction	☐ Osteoarthritis	☐ Osteoporosis	☐ Other – specify
☐ Parkinson's disease	☐ Peptic ulcer disease	☐ Peripheral vascular disease	☐ Renal disease	☐ Rheumatological disease
☐ Vaccination – fluvax given this season	☐ Vaccination – no fluvax this season	☐ Wounds (pressure injury / skin tears / chronic wounds)		

Provisional diagnosis *[insert free text]*

Services currently involved with resident *[insert free text]*

Referrals made by RaSS

Referrals	Representative name
[insert free text]	*[insert free text]*

Contact made by RaSS

GP contacted by RaSS:	☐ Yes ☐ No ☐ Attempted – unable to contact	Residents' substitute health decision maker contacted by RaSS:	☐ Yes ☐ No ☐ Attempted – unable to contact	
Name of GP contacted:		Substitute health decision maker name and authority:	Name:	☐Tribunal appointed guardian ☐ Attorney appointed under an Advance Health Directive or Enduring Power of Attorney ☐ Statutory Health Attorney
GP phone number:		Substitute health decision makers phone number:		

Triage outcome ☐ Remain in RACF under GP care ☐ Mobile ED assessment team ☐Transfer to hospital

Initial hospital contact assessment template

Queensland Government Insert HHS name Insert HHS RaSS name **Initial Hospital Assessment**	Facility: URN: Family name: Given name (s): Address: Date of birth: Sex: ☐ M ☐ F ☐ I

Situation: *[insert free text]*

Background: *[insert free text]*

Assessment**:** *[insert free text]*

Recommendations for management: *[insert free text]*

Electronic signature:

Created by	Created date	Last modified by	Last modified date

Queensland Government Insert HHS name Insert HHS RaSS name **Initial Hospital Assessment**	Facility: URN: Family name: Given name (s): Address: Date of birth: Sex: ☐ M ☐ F ☐ I

Baseline information

Referral source:	☐ GP ☐ RACF ☐ Inter-hospital transfer ☐ Community service – specify		
Date and time of first contact:	*DD/MM/YYYY HH:MM*	Did the resident arrive with transitional communication documents?	☐ Yes ☐ No
Level of care funded:	☐ Ageing in place ☐ Dementia specific ☐ NDIS funded ☐ Placement pending ☐ Temporary respite		
RACF name:			
RACF address:			
RACF phone number:		RACF fax:	

Baseline functional status

Mobility:	☐ Independently mobile ☐ Independently mobile with supervision ☐ Mobile with 4-pronged walker ☐ Mobile with wheeled walker ☐ Mobile with multi-pronged stick ☐ Mobile with single pronged stick	☐ Mobile with single person assist ☐ Mobile with double person assist ☐ Mobile with wheel-chair ☐ Bed-bound
Cognition:	☐ PAS-CIS score of 0 – 3 or no or minimal cognitive impairment ☐ PAS-CIS score of 4 – 9 or mild cognitive impairment	☐ PAS-CIS score of 10 – 15 or moderate cognitive impairment ☐ PAS-CIS score of 16 – 21 or severe cognitive impairment
Urinary continence:	☐Continent ☐Indwelling catheter ☐Suprapubic catheter ☐Urostomy	☐ Incontinent – occasional ☐ Incontinent – frequent ☐ Double incontinent
Faecal continence:	☐Continent ☐Ileostomy or colostomy	☐ Incontinent – occasional ☐ Incontinent – frequent ☐ Double incontinent
Diet – Solids:	☐ Regular (level 7) ☐ Easy to chew (level 7) ☐ Soft & bite-sized (level 6)	☐ Minced & moist (level 5) ☐Pureed (level 4) ☐Liquidised (level 3)
Diet – Liquids:	☐Thin (level 0) ☐Slightly thick (level 1)	☐Mildly thick (level 2) ☐Moderately thick (level 3) ☐Extremely thick (level 4)
Communication:	☐Normal	☐Receptive dysphasia ☐Expressive dysphasia ☐Aphasia
Hearing:	☐Normal	☐Hearing impaired – hearing aids ☐Hearing impaired – no hearing aids
Vision:	☐Normal	☐Vision impaired – visual aids ☐ Vision impaired – no visual aids
Medication administration	☐ Independent ☐ Supervised	☐ Oral normal ☐ Oral crushed ☐ Gastrostomy
Cultural	☐ Aboriginal or Torres Strait Islander ☐Other – specify ☐ Needs translator – specify language	
Other relevant information:	*[insert free text]*	

Queensland Government Insert HHS name Insert HHS RaSS name **Initial Hospital Assessment**	Facility: URN: Family name: Given name (s): Address: Date of birth: Sex: ☐ M ☐ F ☐ I

Advance Care Plan

Advance Care Plan in existence?	☐ Yes ☐ No	
Nature of Advance Care Plan	☐ Advance Health Directive ☐ Statement of wishes – resident ☐ Statement of wishes – EPOA / SHA ☐ Statement of wishes – SHA	☐ Acute resuscitation plan ☐ Facility-specific document ☐ Other -specify
Advance Care Plan uploaded to The Viewer	☐ Yes ☐ No – copy faxed to Office of Advance Care Planning ☐ No – copy not sighted	

Vital signs Date and time recorded:

Temperature:	^{o}C	Responsiveness (AVPU or GCS):	
Pulse rate:	bpm	BGL:	mmol/L
Blood pressure:	mmHg	Pain: Numerical rating scale (N/10)	
Respiratory rate:	bpm	Pain: PAINAD (N/10)	

Comorbidities

☐ AIDS / HIV	☐ Anaemia	☐ Anticoagulated	☐ Any malignancy, including leukaemia and lymphoma	☐ Asthma
☐ Atrial fibrillation	☐ Cerebrovascular disease	☐ Chronic pulmonary disease	☐ Congestive cardiac failure	☐ Dementia
☐ Depression	☐ Diabetes with chronic complications	☐ Diabetes without chronic complications	☐ Hemiplegia or paraplegia	☐ Hypertension
☐ Hyperlipidemia / dyslipidemia	☐ Hypothyroidism	☐ Ischemic heart disease	☐ Liver disease – mild	☐ Liver disease – moderate or severe
☐ Metastatic solid tumour	☐ Myocardial infarction	☐ Osteoarthritis	☐ Osteoporosis	☐ Other – specify
☐ Parkinson's disease	☐ Peptic ulcer disease	☐ Peripheral vascular disease	☐ Renal disease	☐ Rheumatological disease
☐ Vaccination – fluvax given this season	☐ Vaccination – no fluvax this season	☐ Wounds (pressure injury / skin tears / chronic wounds)		

Queensland Government Insert HHS name Insert HHS RaSS name **Initial Hospital Assessment**	Facility: URN: Family name: Given name (s): Address: Date of birth: Sex: ☐ M ☐ F ☐ I

Cognition assessment / delirium screen		
Alertness	☐ Normal (fully alert, not agitated throughout assessment) = 0 ☐ Mild sleepiness for < 10 seconds after waking, then normal = 0 ☐ Clearly abnormal = 4	
AMT 4 (age, date of birth, place, current year)	☐ No mistakes = 0 ☐ 1 mistake = 1 ☐ 2 or more mistakes / untestable = 2	
Attention (months of year backwards)	☐ Achieves 7 months or more correctly = 0 ☐ Starts but scores < 7 months or refuses to start = 1 ☐ Untestable (cannot start because unwell, drowsy, inattentive) = 2	
Acute change or fluctuating course (over last 2 weeks and still evident in last 24 hours)	☐ No = 0 ☐ Yes = 4	
4AT score	☐ 0 = delirium or severe cognitive impairment unlikely	☐ 1- 3 possible cognitive impairment, ☐ >/=4 = possible delirium

Falls risk			
Number of falls in past 6 months		Is this presentation related to the fall	☐ Yes ☐ No

Skin integrity check			
Skin integrity check results	☐ Stage 1 pressure injury ☐ Stage 2 pressure injury ☐ Stage 3 pressure injury ☐ Stage 4 pressure injury ☐ Unstageable pressure injury ☐ Suspected deep tissue injury	☐ Arterial ulcer ☐ Venous or gravitational ulcer ☐ Chronic wound present – cause unclear ☐ Other chronic wound – specify	☐ Skin tear ☐ Laceration ☐ Abrasion ☐ Skin intact

Provisional diagnosis *[insert free text]*

Services currently involved with resident *[insert free text]*

Referrals made by RaSS *[insert free text]*

Referrals	Representative name

Contacts by RaSS

GP contacted by RaSS:	☐ Yes ☐ No ☐ Attempted – unable to contact	Residents' substitute health decision maker contacted by RaSS:	☐ Yes ☐ No ☐ Attempted – unable to contact	
Name of GP contacted:		Substitute health decision maker name and authority:	Name:	☐Tribunal appointed guardian ☐ Attorney appointed under an Advance Health Directive or Enduring Power of Attorney ☐ Statutory Health Attorney
GP phone number:		Substitute health decision makers phone number:		

Substitutive care assessment template

Queensland Government Insert HHS name Insert HHS RaSS name **Mobile ED Assessment**	Facility: URN: Family name: Given name (s): Address: Date of birth: Sex: ☐ M ☐ F ☐ I

Situation: *[insert free text]*

Background: *[insert free text]*

Assessment: *[insert free text]*

Recommendations for management: *[insert free text]*

Electronic signature:

Created by	Created date	Last modified by	Last modified date

Queensland Government Insert HHS name Insert HHS RaSS name **Mobile ED Assessment**	Facility: URN: Family name: Given name (s): Address: Date of birth: Sex: ☐ M ☐ F ☐ I

Baseline information

Referral source:	☐ GP ☐ RACF ☐ Inter-hospital transfer ☐ Community service – specify		
Date and time of first contact:	DD/MM/YYYY HH:MM	Did the resident arrive with transitional communication documents?	☐ Yes ☐ No
Level of care funded:	☐ Ageing in place ☐ Dementia specific ☐ NDIS funded ☐ Placement pending ☐ Temporary respite		
RACF name:			
RACF address:			
RACF phone number:		RACF fax:	

Baseline functional status

Mobility:	☐ Independently mobile ☐ Independently mobile with supervision ☐ Mobile with 4-pronged walker ☐ Mobile with wheeled walker ☐ Mobile with multi-pronged stick ☐ Mobile with single pronged stick	☐ Mobile with single person assist ☐ Mobile with double person assist ☐ Mobile with wheel-chair ☐ Bed-bound
Cognition:	☐ PAS-CIS score of 0 – 3 or no or minimal cognitive impairment ☐ PAS-CIS score of 4 – 9 or mild cognitive impairment	☐ PAS-CIS score of 10 – 15 or moderate cognitive impairment ☐ PAS-CIS score of 16 – 21 or severe cognitive impairment
Urinary continence:	☐Continent ☐Indwelling catheter ☐Suprapubic catheter ☐Urostomy	☐ Incontinent – occasional ☐ Incontinent – frequent ☐ Double incontinent
Faecal continence:	☐Continent ☐Ileostomy or colostomy	☐ Incontinent – occasional ☐ Incontinent – frequent ☐ Double incontinent
Diet – Solids:	☐ Regular (level 7) ☐ Easy to chew (level 7) ☐ Soft & bite-sized (level 6)	☐ Minced & moist (level 5) ☐Pureed (level 4) ☐Liquidised (level 3)
Diet – Liquids:	☐Thin (level 0) ☐Slightly thick (level 1)	☐Mildly thick (level 2) ☐Moderately thick (level 3) ☐Extremely thick (level 4)
Communication:	☐Normal	☐Receptive dysphasia ☐Expressive dysphasia ☐Aphasia
Hearing:	☐Normal	☐Hearing impaired – hearing aids ☐Hearing impaired – no hearing aids
Vision:	☐Normal	☐Vision impaired – visual aids ☐ Vision impaired – no visual aids
Medication administration	☐ Independent ☐ Supervised	☐ Oral normal ☐ Oral crushed ☐ Gastrostomy
Cultural	☐ Aboriginal or Torres Strait Islander ☐Other – specify ☐ Needs translator – specify language	
Other relevant information:	*[insert free text]*	

Queensland Government

Insert HHS name

Insert HHS RaSS name

Mobile ED Assessment

Facility:
URN:
Family name:
Given name (s):
Address:
Date of birth: Sex: ☐ M ☐ F ☐ I

Advance Care Plan

Advance Care Plan in existence?	☐ Yes ☐ No	
Nature of Advance Care Plan	☐ Advance Health Directive ☐ Statement of wishes – resident ☐ Statement of wishes – EPOA / SHA ☐ Statement of wishes – SHA	☐ Acute resuscitation plan ☐ Facility-specific document ☐ Other -specify
Advance Care Plan uploaded to The Viewer	☐ Yes ☐ No – copy faxed to Office of Advance Care Planning ☐ No – copy not sighted	

Comorbidities

☐ AIDS / HIV	☐ Anaemia	☐ Anticoagulated	☐ Any malignancy, including leukaemia and lymphoma	☐ Asthma
☐ Atrial fibrillation	☐ Cerebrovascular disease	☐ Chronic pulmonary disease	☐ Congestive cardiac failure	☐ Dementia
☐ Depression	☐ Diabetes with chronic complications	☐ Diabetes without chronic complications	☐ Hemiplegia or paraplegia	☐ Hypertension
☐ Hyperlipidemia / dyslipidemia	☐ Hypothyroidism	☐ Ischemic heart disease	☐ Liver disease – mild	☐ Liver disease – moderate or severe
☐ Metastatic solid tumour	☐ Myocardial infarction	☐ Osteoarthritis	☐ Osteoporosis	☐ Other – specify
☐ Parkinson's disease	☐ Peptic ulcer disease	☐ Peripheral vascular disease	☐ Renal disease	☐ Rheumatological disease
☐ Vaccination – fluvax given this season	☐ Vaccination – no fluvax this season	☐ Wounds (pressure injury / skin tears / chronic wounds)		

Mobile ED assessment information

Referral date:

Arrival time:

Time at resident:

Care complete time:

Assessment performed by:

Queensland Government Insert HHS name Insert HHS RaSS name **Mobile ED Assessment**	Facility: URN: Family name: Given name (s): Address: Date of birth: Sex: ☐ M ☐ F ☐ I

Vital signs Date and time recorded:

Temperature:	°C	Responsiveness (AVPU or GCS):	
Pulse rate:	bpm	BGL:	mmol/L
Blood pressure:	mmHg	Pain: Numerical rating scale (N/10)	
Respiratory rate:	bpm	Pain: PAINAD (N/10)	

Medication list

Drug name	Dose	Frequency

Allergies:

Queensland Government Insert HHS name Insert HHS RaSS name **Mobile ED Assessment**	Facility: URN: Family name: Given name (s): Address: Date of birth: Sex: ☐ M ☐ F ☐ I

Cognition assessment / delirium screen		
Alertness	☐ Normal (fully alert, not agitated throughout assessment) = 0 ☐ Mild sleepiness for < 10 seconds after waking, then normal = 0 ☐ Clearly abnormal = 4	
AMT 4 (age, date of birth, place, current year)	☐ No mistakes = 0 ☐ 1 mistake = 1 ☐ 2 or more mistakes / untestable = 2	
Attention (months of year backwards)	☐ Achieves 7 months or more correctly = 0 ☐ Starts but scores < 7 months or refuses to start = 1 ☐ Untestable (cannot start because unwell, drowsy, inattentive) = 2	
Acute change or fluctuating course (over last 2 weeks and still evident in last 24 hours)	☐ No = 0 ☐ Yes = 4	
4AT score	☐ 0 = delirium or severe cognitive impairment unlikely	☐ 1- 3 possible cognitive impairment, ☐ >/=4 = possible delirium

Falls risk			
Number of falls in past 6 months		Is this presentation related to the fall	☐ Yes ☐ No

Skin integrity check			
Skin integrity check results	☐ Stage 1 pressure injury ☐ Stage 2 pressure injury ☐ Stage 3 pressure injury ☐ Stage 4 pressure injury ☐ Unstageable pressure injury ☐ Suspected deep tissue injury	☐ Arterial ulcer ☐ Venous or gravitational ulcer ☐ Chronic wound present – cause unclear ☐ Other chronic wound – specify	☐ Skin tear ☐ Laceration ☐ Abrasion ☐ Skin intact

Provisional diagnosis ***[insert free text]***

Services currently involved with resident ***[insert free text]***

Referrals made by RaSS ***[insert free text]***

Referrals	Representative name

Contacts by RaSS

GP contacted by RaSS:	☐ Yes ☐ No ☐ Attempted – unable to contact	Residents' substitute health decision maker contacted by RaSS:	☐ Yes ☐ No ☐ Attempted – unable to contact	
Name of GP contacted:		Substitute health decision maker name and authority:	Name:	☐Tribunal appointed guardian ☐ Attorney appointed under an Advance Health Directive or Enduring Power of Attorney ☐ Statutory Health Attorney
GP phone number:		Substitute health decision makers phone number:		

RaSS discharge template:

Queensland Government Insert HHS name Insert HHS RaSS name **Discharge Summary**	Facility: URN: Family name: Given name (s): Address: Date of birth: Sex: ☐ M ☐ F ☐ I

Type of RaSS episode of care

☐ Telephone triage ☐ Gerontic nursing hospital assessment ☐ Mobile ED assessment

Situation:

Background:

Assessment (include nurse care assessment and provision)

Recommendations *(Nurse care planning, outstanding issues/results for GP follow up, clinical referral recommendations and date of review. Clarify ARP status, ensure recommended criteria for escalation of clinical issues noted by medical team)*

Insert HHS RaSS name and contact details

Telephone:

Email:

Queensland Government Insert HHS name Insert HHS RaSS name **Discharge Summary**	Facility: URN: Family name: Given name (s): Address: Date of birth: Sex: ☐M ☐ F ☐ I

Electronic Signature:

Created By Created Date Last Modified By Last Modified Date

GP and RACF details

Name of GP:		RACF address:	
GP phone number:		RACF phone number:	
GP fax number:		RACF fax number:	

Referrals made by RaSS:

Referrals	Representative Name

Contacts by RaSS

GP contacted by RaSS:	☐ Yes ☐ No ☐ Attempted – unable to contact	Residents' substitute health decision maker contacted by RaSS:	☐ Yes ☐ No ☐ Attempted – unable to contact	
Name of GP contacted:		Substitute health decision maker name and authority:	Name:	☐Tribunal appointed guardian ☐ Attorney appointed under an Advance Health Directive or Enduring Power of Attorney ☐ Statutory Health Attorney
GP phone number:		Substitute health decision makers phone number:		

IMAR/EDDMAR on discharge: ☐ Yes ☐ No

RaSS discharge documentation: ☐ Yes ☐ No

Disposition destination: ☐ Discharged to care of GP and RACF ☐ Admitted to Hospital in the Home

☐ Other – specify

Discharge date:

Discharge time:

Insert HHS RaSS name and contact details

Telephone:

Email:

RaSS follow-up template:

Queensland Government Insert HHS name Insert HHS RaSS name **Follow up contact**	Facility: URN: Family name: Given name (s): Address: Date of birth: Sex: ☐ M ☐ F ☐ I
Electronic signature: Created by Created date Last modified by Last modified date	

Interim follow up

Time post discharge to follow up (days):

Resident status: ☐ Alive ☐ Dead

Representations to ED? ☐ Yes ☐ No If yes, date of representation:

Referrals fulfilled? ☐ Yes ☐ No If no, action taken:

Readmission to hospital? ☐ Yes ☐ No If yes, date of readmission:

Complications since discharge:

Delirium ☐ Yes ☐ No

Pressure injuries ☐ Yes ☐ No If yes, location of PI:

Falls ☐ Yes ☐ No

Other complications since discharge (specify):

Recommendations provided:

Queensland Government Insert HHS name Insert HHS RaSS name Follow up contact	Facility: URN: Family name: Given name (s): Address: Date of birth: Sex: ☐ M ☐ F ☐ I
Electronic signature: Created by Created date Last modified by Last modified date	

Follow up at 7 days post-discharge:

Resident status: ☐ Alive ☐ Dead

Representations to ED? ☐ Yes ☐ No If yes, date of representation:

Referrals fulfilled? ☐ Yes ☐ No If no, action taken:

Readmission to hospital? ☐ Yes ☐ No If yes, date of readmission:

Complications since discharge:

Delirium ☐ Yes ☐ No

Pressure injuries ☐ Yes ☐ No If yes, location of PI:

Falls ☐ Yes ☐ No

Other complications since discharge (specify):

Recommendations provided:

Appendix 2: Sample marketing tools

Sample resident / family brochure

Who can I talk to if I have any concerns?

You should continue to discuss any concerns with your GP or your relatives GP and the director of nursing or registered nurse in charge at the RACF.

Contact the RaSS team at:

Information for residents of aged care facilities and resident relatives

Queensland Health would like to acknowledge with thanks the Metro South Hospital and Health Service in the production of this information

Rapid Results Program
Working together | transforming healthcare

Queensland Health

Residential Aged Care Facility Support Service (RaSS)

A program for high quality collaborative acute health care delivery to residents of aged care facilities

Queensland Government

What is a RaSS?

A RaSS is a partnership between general practitioners (GPs), residential aged care facilities (RACFs), hospital and health services and community service providers to ensure right care is received at the right place at the right time.

The service aims to provide the best care for residents of aged care facilities.

The RaSS provides clinical advice via telephone with experienced clinical nurse consultants, who have emergency assessment skills and are supported by specialist doctors.

Aims

The RaSS aims to link residents of aged care facilities with acute health care needs, to the most appropriate service.

If you or your relative becomes unwell, the GP or nursing staff at the RACF, can contact the RaSS for advice and support.

If necessary, the RaSS can arrange for a specialist nurse or doctor to visit the RACF. This means that you or your relative can receive care in familiar surrounds.

If transfer to hospital is required, the RaSS can ensure that the receiving emergency department is made aware of the transfer.

How does it work?

If you or your relative is unwell, the GP and RACF staff will assess you or your relative.

If the GP and RACF staff determine you or your relative are critically unwell, an ambulance will be called, unless you or your relative have expressed a wish to not be transferred to hospital.

If your GP requires advice, the RaSS may be contacted.

The RaSS may then refer to:

- a community based service
- a hospital based service
- a visit in the RACF or a telehealth consultation by the RaSS nurse practitioner or a specialist in emergency medicine or geriatrics.

Will my GP be contacted if I am unwell?

Yes - the GP is integral to care and will be contacted prior to the RaSS referral.

If this has not occurred, the RaSS service will contact the GP to involve them in any care decisions made.

Note: it is suggested that resident / family brochures be translated into the most common non-English speaking backgrounds to ensure accessibility of information to all

Sample GP fact sheet

Queensland Health

Residential Aged Care Facility Support Service (RaSS)

A program for high quality collaborative acute healthcare delivery to

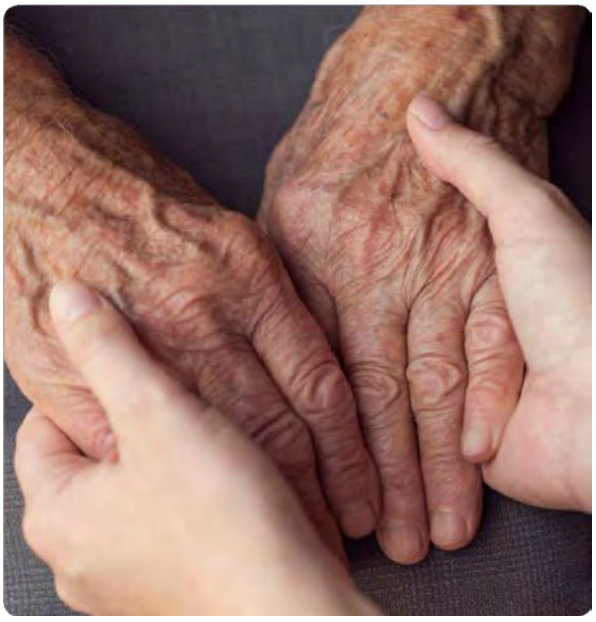
What is a RaSS?

A RaSS is a partnership between general practitioners (GPs), residential aged care facilities (RACFs), hospital and health services and community service providers.

The RaSS is a single point of contact for RACF staff and GPs with residents who have acute health care needs, where these exceed the capability of the GP and RACF to manage independently.

The service aims to provide the best care for residents of aged care facilities in the most appropriate location.

Clinical advice is provided via telephone with experienced clinical nurse consultants, who have emergency assessment skills and are supported by specialist doctors.



Examples of types of care able to be delivered in the RACF include:

- clinical assessment and care planning when you require a second opinion
- IV therapies
- linking of residents to community based providers or hospital based services.

Rapid Results Program
Working together | transforming healthcare

Queensland Government

Aims

The RaSS aims to improve quality of care for residents of aged care facilities, while also improving efficiency of service delivery.

It provides clinical advice and collaborative care planning and may link residents with acute health care needs to:

- community based services
- hospital based services
- a visit in the facility or a telehealth consultation by a RaSS nurse practitioner or a specialist in emergency medicine or geriatrics.

Assessment of the teams' performance will be undertaken against a range of measures, including:

1. Patient centred measures, such as:
    - mortality rates
    - morbidity rates (pressures ulcers, falls, blood stream infections and medication incidents)
    - unplanned admissions to hospital within seven days of contact
    - patient and family satisfaction.
2. Service related measures, such as:
    - proportion of residents of aged care facilities discharged with a discharge summary
    - number of avoidable emergency department presentations
    - proportion of hospital separations for residents of aged care facilities with a component of acute substitutive care admission in the episode of care
    - proportion of residents of aged care facilities discharged with a discharge summary

How does it work?

We have partnered with GPs, RACFs and hospital specialist clinicians to develop clinical pathways to guide referrals to the RaSS.

No care planning for individual residents will be undertaken without involvement of the GP.
RaSS hours of operation:

RaSS contact details:

Your enquiry will be answered by a clinical nurse consultant, who has access when required to a specialist in emergency medicine or geriatrics.

Queensland Health would like to acknowledge with thanks the Metro South Hospital and Health Service in the production of this information
Residential aged care facility support service (RaSS)
Information for general practitioners

Sample Health Professionals fact sheet

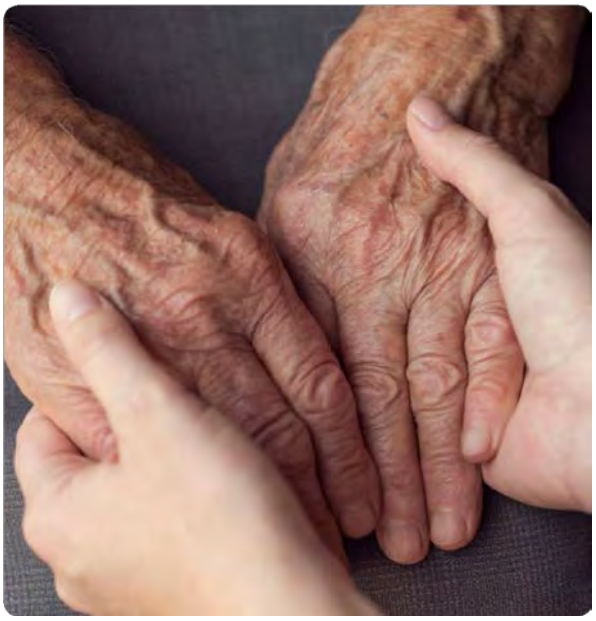
Queensland Health

Residential Aged Care Facility Support Service (RaSS)

A program for high quality collaborative acute healthcare delivery to residents of aged care facilities

What is a RaSS?

A RaSS is a partnership between general practitioners (GPs), residential aged care facilities (RACFs), hospital and health services and community service providers.
The RaSS is a single point of contact for RACF staff and GPs with residents who have acute health care needs, where these exceed the capability of the GP and RACF to manage independently.



The service aims to support the best care for residents of aged care facilities, in the most appropriate location.

Clinical advice is provided via telephone with experienced clinical nurse consultants, who have emergency assessment skills and are supported by specialist doctors.

Examples of types of care able to be delivered in the RACF include:

- clinical assessment and care planning when you require a second opinion
- IV therapies
- linking of residents to community based providers or hospital based services.

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Aims

The RaSS aims to improve quality of care for residents of aged care facilities, while also improving efficiency of service delivery.
It provides clinical advice and collaborative care planning and may link residents with acute health care needs to:

- community based services
- hospital based services
- a visit in the facility or a telehealth consultation by a RaSS nurse practitioner or a specialist in emergency medicine or geriatrics.

How does it work?

In a medical emergency, particularly where the resident has unstable vital signs, RACF staff should always dial 000 to call an ambulance unless the resident has an Advance Care Directive or Advance Care Plan, expressing a preference not to be transferred and where such transfer would not improve quality of life.

BEFORE calling the RaSS, RACF staff should:

- assess vital signs and confirm stable
- consult the *Management of acute care needs of RACF residents* clinical pathways
- consult the residents' GP for advice
- if the GP recommends and the resident or relative provides consent, contact the RaSS.

RaSS hours of operation:

RaSS contact details:

Your enquiry will be answered by a clinical nurse consultant, who has access when required to a specialist in emergency medicine or geriatrics.

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Appendix 3: Gerontic friendly ED environmental modifications

Photo 1: Triage

1. Clear signage with large letters on matt background
2. Hearing loop induction with eye-height signage

Photo 2: ED cubicles example 1:

1. Access to natural light
2. Orientation board
3. Clock

You are in the XX Hospital Emergency Department

Date:

Your nurse is:

Your doctor is:

You are currently awaiting:

Photo 3: ED cubicle example 2:

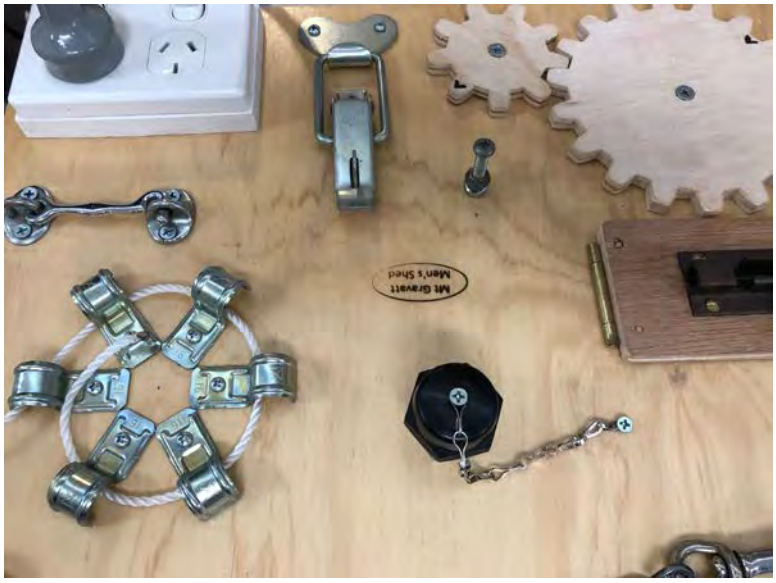
1. Medical equipment hidden
2. Stimulation / distraction item for cognitively impaired
3. High-backed reclining chair as an alternative to ED trolley

Photo 4: Toilet with high contrast toilet seat and hand-rail

Photo 5: Cognition appropriate activity box

Source: Frederick Graham, Princess Alexandra Hospital, Dementia and Delirium Clinical Nurse Consultant

Photo 6a and b: Cognition appropriate activity trolley with sample activity board for males: note the power point is not connected



Source: Care of Older persons (COOP) multidisciplinary interest group, QEII ED

Photo 7: Distraction apron

Source: Frederick Graham, Princess Alexandra Hospital, Dementia and Delirium Clinical Nurse Consultant

Abbreviations

ABF	Activity based funding
ACS	Aged Care Services
CHIP	Community hospital interface program
ED	Emergency Department
EDDMAR	Emergency Department Discharge Medication Administration Record
GEMITH	Geriatric evaluation and management in the home
GP	General Practice
HITH	Hospital in the home
IMAR	Interim medication administration record
LOS	Length of stay
PEG	Percutaneous endoscopic gastrostomy
QH	Queensland Health
RACF	Residential aged care facility
RaSS	RACF support service

Glossary

Term (abbreviation)	Definition	Source
Care Setting	Location in which the RaSS service provides care to the patient. The decision regarding RaSS care setting is to be patient-focused, taking into consideration the psychological, physical and environmental needs of the patient and not influenced by the funding models Care settings can include, but are not exclusive to, patient's permanent or temporary Residential Aged Care Facility, or hospital settings	Modified from HITH Guidelines 2012
Clinical Governance	"The system by which the governing body, managers, clinicians and staff share responsibility and accountability for the quality of care, continuously improving, minimising risks and fostering an environment of excellence in care for consumers"	ACHS Standard 1
Clinical handover	Transfer of professional responsibility and accountability for some or all aspects of care for a patient, or group of patients, to another person or professional group on a temporary or permanent basis	National Safety and Quality Health Service Standards (2012)
Clinical consumables	Recurrently required consumables of a medical or surgical nature including drug supplies that are provided by the RaSS (not including capital equipment or equipment repairs and not including consumables provided by the RACF)	Modification from National Health Data Dictionary v16
Emergency Department Discharge Medication Administration Record (EDDMAR)	"The EDDMAR is produced by a medical officer in the ED of a QH facility when a patient is discharged to a residential aged care facility (RACF) and a pharmacist is unavailable to produce an Interim Medication Administration Record (IMAR). It is designed to be used in combination with the RACF patient's long-term medication chart, for up to 5 days post-discharge until the resident's General Practitioner and community pharmacy can arrange ongoing medications for the patient"	CARE-PACT EDDMAR frequently asked questions

Interim medication administration record (IMAR)	"An IMAR is a comprehensive list of a resident's discharge medication regimen (including details of changes to the pre-admission regimen) that is generated by the hospital pharmacist for use as a record of administration of dispensed medications by residential aged care facility (RACF) staff. The IMAR is designed to replace the pre-existing long-term RACF medication chart and is valid for up to five days post-discharge until the resident's long-term RACF medication chart can be updated by their GP"	CARE-PACT IMAR frequently asked questions
Medication Management	Process whereby the medication requirements of RACF residents are met	Adapted from HITH Guidelines 2012
Pathways	Standardised, evidence-based multidisciplinary management plans, which identify an appropriate sequence of clinical interventions, timeframes, milestones and expected outcomes	Queensland Health Clinical Pathways Board
Residential aged care facility support services (RaSS)	Residential aged care facility support services (RaSS) are QH funded services that provide some or all of the following acute care services to residents of aged care facilities to facilitate care in the RACF environment (where clinically appropriate) and improve quality of care across the care continuum: • ED substitutive care – acute assessment or care in the RACF environment as an alternative to ED transfer; the types of care able to be delivered will be determined by the scope of practice of individual RaSS staffing models • Telephone triage – telephone assessment of acute care needs and matching the care need to the most appropriate care delivery service • Specialist consultative services via telehealth to RACF residents or face to face visits • Gerontic nursing assessment for RACF residents presenting to ED or admitted to hospital • Discharge planning, co-ordination and transitional communication for RACF residents presenting to ED or admitted to hospital	RaSS guideline definition

Residential aged care facilities (RACFs)	Residential aged care facilities are facilities whose primary purpose is the provision of residential care to the elderly where these are funded under the Aged Care Act and are subject to Commonwealth reporting to the System for Payment of Aged Residential Care or those funded or are operated under the National Aboriginal and Torres Strait Islander Aged Care Program. It specifically excludes facilities where the primary purpose is provision of services to those with mental health illness or disability	CARE-PACT clinical governance procedure

References

1. Burkett, E. and I. Scott, *CARE-PACT: a new paradigm of care for acutely unwell residents in aged care facilities.* Aust Fam Physician, 2015. **44**(4): p. 204-9.
2. Healthcare Improvement Unit, C.E.D., *Health Innovation Fund: Evaluation of Round 1 Project Final Outcome Evaluation Report - March 2017: Comprehensive Aged Residents Emergency and Partners in Assessment, Care and Treatment (CARE-PACT)*, D.o. Health, Editor. 2017, Department of Health, Queensland Government Brisbane.