Principles for care delivery in Residential Aged Care

Call us 1800 111 644

myhomehospital.sa.gov.au

Government of South Australia

SA Health

This document provides broad principles for the delivery of My Home Hospital services in Residential Aged Care Homes (RACHs) for each stage in the patient journey. It has been developed and refined following engagement with stakeholders from the Department of Health, Disability and Ageing, Aged Care Quality and Safety Commission and the aged care sector.

Recognising that each home has its own local processes, it addresses aspects of care where the My Home Hospital team and RACH interface.

Aspects of care discussed in this document that align with the Australian Commission on Safety and Quality in Healthcare's National Safety Quality Health Service Standards (NSQHSS) include:

- Identification and Referral (NSQHSS 2, 5 and 6)
- Admission (NSQHSS 2 and 5)
- Care Provision (NSQHSS 2, 3, 4, 5 and 6)
- Escalation (NSQHSS 6 and 8)
- Discharge (NSQHSS 2, 5 and 6)

Please note that throughout the document:

- where the terms 'patient' or 'resident' are used, this should also be taken to refer to the person's Substitute Decision Maker or Person Responsible as appropriate
- where the term 'home' is used, it also refers to RACH
- approved providers of residential aged care services remain responsible for compliance with Commonwealth legislation and the provision of services that promote the safety and quality of care for older Australians.

About the Service

Service overview

SA Health's My Home Hospital service provides acute hospital care to people in their own homes, including residents in Residential Care Homes (RACHs).

My Home Hospital is an SA Health service delivered by Amplar Health Home Hospital (AHHH) and brings care to the residents in their RACHs in the form of doctors, nurses, and allied health practitioners. AHHH is nationally accredited to the National Safety and Quality Health Service (NSQHS) Standards.

The vision of My Home Hospital is for all people, and especially for older people to have the choice to receive hospital-level care at home, including their home in a RACH, avoiding unnecessary transfers to hospital and ensuring the interface between care systems is seamless and safe.

For residents of aged care homes, avoiding unnecessary transfers to a physical hospital can be particularly beneficial, particularly if the older person experiences cognitive impairment or symptoms of dementia. Receiving care within the home also potentially reduces the risk of hospital acquired infections and other complications. My Home Hospital is a public hospital service and is available at no cost to eligible patients.

Model of care

My Home Hospital is a medically-led service, with medical leads and staff specialists providing senior medical and nursing cover 24 hours a day, 7 days a week. It offers:

- Personalised care plans developed in partnership with patients, loved ones, carers and the person's usual health care team.
- Regular reviews of patient's care requirements, conducted both face-to-face and virtually, with care tailored to meet individual patient needs.
- Face-to-face in-home visits at least once a day and as often as the person's condition requires, provided by experienced Registered Nurses (RNs), paramedics and allied health providers.
- Virtual ward rounds daily with the medical officer, the resident and, where possible, family and carers, and the RACH RNs, with more frequent medical review as required for patient safety, (including face to face medical reviews), appropriate escalation, and clinically appropriate and efficient discharge processes.
- In addition to in-home visits, My Home Hospital uses remote monitoring technology to enable the care team to stay in touch with patients at any time and to review observations such as pulse, temperature and blood pressure. Data collected via remote monitoring devices is immediately available to senior nursing and medical staff in the Virtual Care Centre, who can then respond to any issues.
- My Home Hospital provides comprehensive medical care, just as if a resident was an in-patient in a physical hospital, and welcomes discussion/questions about all health care needs with the nursing and medical team.

More information about My Home Hospital is available at myhomehospital.sa.gov.au.

Credentialing of My Home Hospital staff

My Home Hospital staff meet requirements for entry to an RACH, such as relevant vaccination and criminal history screening. If your RACH has additional requirements, please advise My Home Hospital.

The patient journey

Identification and referral

Patients can be referred to My Home Hospital by their GP, medical specialist, a nurse practitioner, a RACH Senior Registered Nurse, an SA Ambulance Service paramedic, SA Virtual Care Service or from an emergency department or hospital.

Aged care staff have a key role in helping to identify potentially eligible and suitable patients for My Home Hospital. It can be helpful to have the discussion with your residents and their GPs about whether the resident would like to consider receiving acute care in the RACH rather than up transfer to a hospital. My Home Hospital could be an option for this in the event they become unwell. The patient's wishes can then be incorporated into their care plan or Advance Care Directive.

The My Home Hospital team is available to provide education and information sessions for your executive or management team, clinical staff, GPs that provide service to residents, residents and their families. These sessions can be helpful because they build understanding of the service, eligibility and suitability criteria, referral processes and service responsiveness to ensure a streamlined process.

SA Health's Integrated Care Systems team oversees My Home Hospital. It can also provide information and other resources, and can be reached at Health.MyHomeHospital@sa.gov.au

Who is eligible for My Home Hospital?

To identify potential patients most appropriate and most likely to benefit from My Home Hospital, SA Health undertook extensive engagement with key referrers and consumers throughout the development and inception of the service. Further feedback is always welcome.

My Home Hospital is an acute care service. This means that to be eligible for My Home Hospital, the resident must have care needs that would have otherwise required hospital inpatient care. Patients must also:

- live in one of service areas:
  - the Adelaide metropolitan area
  - Gawler and Mount Barker regions and their surrounds
  - the Southern Fleurieu Peninsula towns of Goolwa, Goolwa North, Goolwa South, Goolwa Beach, Middleton, Port Elliot, McCracken, Hayborough, Victor Harbor and Encounter Bay
- be Medicare eligible
- consent to receive My Home Hospital services, which can be provided by a Substitute Decision-Maker or Person Responsible if relevant. More information about consent to medical treatment and healthcare, decision making capacity and Advance Care Directives can be found in the *For Further Information* section at the end of the document.

Once a referral is made, the My Home Hospital clinical team will assess the safety and appropriateness of providing care in the RACH. This process considers factors including:

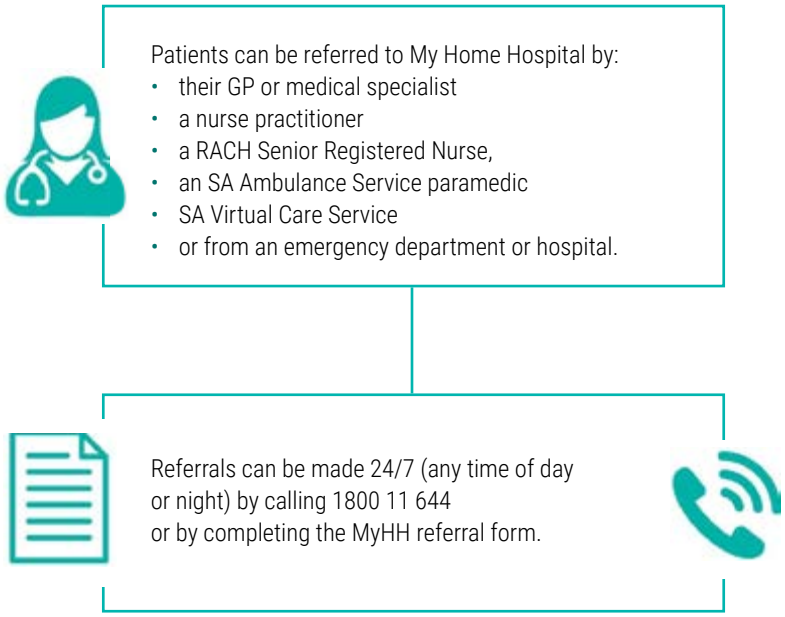
- the patient's clinical condition
- the level of monitoring and oversight required
- any safety considerations, such as the ability to maintain intravenous (IV) access if required.

Clinical advice and support for referrers about patient suitability for My Home Hospital and diagnostic work-up that may be required is available from the **My Home Hospital Virtual Care Centre 24 hours a day, 7 days a week on 1800 111 644** or at myhomehospital.sa.gov.au.

Patients who are currently admitted to Care Awaiting Placement (CAP) or to the Transition Care Program (TCP) delivered in a facility based residential setting are not eligible for admission to My Home Hospital. However, patients admitted to the Transition Care Program delivered in a community setting (e.g., the persons own home) are eligible for My Home Hospital, but must either be placed on leave from TCP care or be discharged from TCP prior to being admitted to My Home Hospital.

Making a referral

A resident (or their Substitute Decision-Maker/Person Responsible, where relevant) must always provide their consent for a My Home Hospital referral.



The clinical governance and responsibility for care of the patient remains with the referrer until admission is confirmed.

During the referral assessment, the My Home Hospital team may contact the referrer, RACH and resident and their loved ones (or their Substitute Decision-Maker/Person responsible) for additional information, if required.

Referral information, including the referral form, is available at myhomehospital.sa.gov.au

Once the referral has been accepted, a care coordinator (RNs who work in the Virtual Care Centre) will contact the RACH to discuss the admission process and advise when the first visit will occur. If the patient has been referred from off-site, such as a hospital, transport arrangements back to the RACH will also be confirmed.

Relevant and supporting documentation and information that would normally be sent with a patient from an RACH on a transfer to a hospital (e.g. as part of an RACH hospital pack or transfer pack) should be provided to the My Home Hospital team at point of referral or as soon as possible thereafter. This may include any information about the resident's medical history, medication charts, Advance Care Directive, decision-making capacity, care plan and results of any recent tests, such as blood tests, ultrasounds or x-rays.

Admission

My Home Hospital patients are admitted under the care of a medical officer who is credentialed with and employed by Amplar Health Home Hospital to provide services in My Home Hospital. The My Home Hospital doctors will provide medical care to the patient while they are admitted and the patient's usual GP and RACH will be notified.

My Home Hospital clinicians have clinical governance over the resident's care throughout their admission, with a clinical handover back to the GP on discharge from the service. In line with governance and funding regulations for virtual hospital patients, it is not possible to bill Medicare if a general practitioner provides services to a resident while an in-patient of My Home Hospital.

Care planning

At the point of admission, a MyHH care coordinator, in consultation with the patient and the My Home Hospital medical team will develop an individualised care plan. The care coordinator will also contact the facility to discuss the care plan, care times and escalation processes and ensure a smooth interface between My Home Hospital and usual care. If there are any changes required to the usual care provided, the My Home Hospital care coordinator will discuss them with RACH staff.

The resident (or their Substitute Decision-Maker/Person Responsible where relevant) will be asked for their consent to receive My Home Hospital treatment. More information about consent to medical treatment and healthcare, decision making capacity and Advance Care Directives can be found in the *For Further Information* section at the end of the document.

A daily virtual ward round is led by the My Home Hospital medical team, supported by the care coordinator to review the care plan, monitor the resident's progress and make any necessary changes to their care. As part of this daily ward round, the My Home Hospital team will speak with the patient (or their Substitute Decision-Maker/Person Responsible) and the relevant RACH RN. Nominating key RACH points of contact for the My Home Hospital service to liaise with throughout the patient's admission will assist with smooth communication processes. The My Home Hospital team welcome the patient's family joining the ward round if desired.

A care coordinator can be contacted at any time on 1800 111 644 by the patient (or their Substitute Decision-Maker/Person Responsible), family or staff if they have any questions, or concerns during admission to My Home Hospital.

First visit and provision of equipment and consumables

Once admitted, an orange kit box will be sent to the RACH facility via courier.

The kit box contains:

- an information pack on top which includes important information about My Home Hospital and information about the condition being treated,
- a Wi-fi and Bluetooth enabled touch-screen tablet and monitoring devices that will measure and record the resident's clinical observations for the care team,
- a My Home Hospital wristband and sign for the resident's room to assist with patient identification as a My Home Hospital patient,
- patient medications relevant to the patient's admission, this may include a paper medication chart for the RACH, if there is a change to their usual medications (or this may be sent via fax or email directly to the home).

As the orange kit box contains medication it must be placed in a secure location outside of the resident's room, such as the nurse's station.

My Home Hospital will provide any additional equipment, medication and consumables relevant to the resident's acute care episode. Any consumables or equipment that are part of usual care for the resident will continue to be provided by the RACH.

During the first onsite visit, a My Home Hospital nurse will set up the remote monitoring equipment and show the resident and staff how to use it. If RACH staff are going to assist the resident to take observations, My Home hospital will ensure the staff are aware of how to use the technology.

An RN or enrolled nurse can perform this check, and the results will immediately be available to the MyHH care coordinator and medical staff in the Virtual Care Centre for review and response if necessary.

The My Home Hospital nurse will apply the wristband at the first visit and this will be routinely checked when providing care. The nurse will also ensure the My Home Hospital sign is displayed clearly in the patient's room. My Home Hospital has a requirement under the National Safety and Quality Health Service Standards to perform patient identification appropriately and safely. To mitigate the risk of patient misidentification, several processes and identification mechanisms, including the wristband and sign are used when a resident is admitted to My Home Hospital. The resident should also be identified as a current My Home Hospital patient through documentation in the resident's RACH medical records at each visit.

If you have any questions about these identification measures or how to use any of the equipment or technology, please speak with the My Home Hospital care coordinator on 1800 111 644.

Patient Kit Box

Contents:

- Touch-screen tablet
- Thermometer
- Pulse Oximeter
- Blood Pressure Machine
- other devices as required

Patient Tablet

Task Screen
The Task screen will be the main screen the patients will need to access. This screen will show all the tasks due for the day. They can tap on the task to complete it.

Care Plan Screen
The Care Plan screen shows the patients goals. Care Plans will be added and updated by the Care Coordinators.

Monitoring Screen
Patient readings and alerts will be monitored on the Clinical Triage Dashboard.

Care provision

Continuity of care and the maintenance of care relationships are important for the health and wellbeing of older people. The Department of Health, Disability and Ageing has agreed that usual care arrangements for a resident, including funding, can continue throughout a My Home Hospital admission.

Facility provisions:

When a resident is admitted to My Home Hospital, the following will continue to be provided by the facility:

- usual equipment,
- consumables,
- aged care supports, for example personal care, meals and other domestic services.

My Home Hospital provisions:

My Home Hospital will provide the following relevant to the resident's acute condition while the resident is admitted:

- medical, nursing and allied health care
- diagnostics
- additional medications
- equipment required.

If there are any questions or concerns, RACH staff should always contact the My Home Hospital medical team on 1800 111 644 for advice and assistance in the first instance. My Home Hospital is a 24 hour a day, 7 day a week service and medical support is always available.

Medication management

Medication management is critical to ensuring resident safety. During the resident's admission to the My Home Hospital service, medical governance sits with the My Home Hospital doctor and, on admission, the patient's usual GP will be informed of this. Therefore, if RACH staff have any concerns or questions about medications during the resident's admission, they should call 1800 111 644 to speak with the My Home Hospital team or speak with the My Home Hospital staff who visit the home.

Each RACH has different systems for managing medications and My Home Hospital is committed to working with facilities to ensure communication and handover regarding a resident's medications meets local needs.

In general, the following will apply:

- On admission, the My Home Hospital team will complete a full medication reconciliation, which will involve the team communicating with the RACH staff and resident.
- While admitted to the My Home Hospital service, the resident will continue to have their RACH medication chart, with usual medication being provided and dispensed by RACH staff as per their usual care. The My Home Hospital team will request a copy of the facility medication chart as part of the daily ward round to ensure safe and appropriate prescribing.
- On admission, My Home Hospital will provide the RACH with a list of the resident's additional medications on the top of the My Home Hospital orange kit box. If any changes are made to the resident's usual list of medications that the RACH provides and administers, or if any PRN medication may be required to be administered by RACH staff, My Home Hospital will communicate directly with the home, provide required interim medication orders and confirm supply.
- Additional medications that are required to treat the resident's acute illness as part of their My Home Hospital admission will be dispensed by the My Home Hospital pharmacy service and administered by My Home Hospital clinicians. If there are any concerns regarding different or multiple medication charts, please call 1800 111 644 to speak with the My Home Hospital team.
- Throughout the admission, My Home Hospital will communicate daily with RACH RNs and the resident about the management of the resident's medications. This will occur as part of the daily virtual ward rounds and by My Home Hospital clinicians attending the RACH.

Communication and handover during the patient's My Home Hospital admission

The National Safety and Quality Health Service Standards requires that hospitals:

"Consider how teams work and communicate with each other within and outside the organisation (across disciplines). Patient identification, procedure matching, clinical handover and communication of critical information in acute care services will often involve multiple clinicians or teams. Given the complexity of health care, these clinicians and teams may change regularly or over time, depending on the needs of the patient. To deliver comprehensive care that is safe and continuous, teamwork and effective communication are critical" (Action 6.4)

My Home Hospital nursing staff visiting the resident to provide care will identify themselves on arrival at the home. They will seek an update from home's nursing staff on the patient's progress and assistance to retrieve the kit box and equipment from where it has been securely stored.

When the visit is complete, My Home Hospital staff will provide a verbal clinical handover to RACH nursing staff and document in the resident's RACH medical records. The RACH can inform the My Home Hospital staff during their visit to the site or home not facility about how this can occur, for instance by providing My Home Hospital staff with access to paper-based medical records or a generic login to allow access to electronic medical records. The My Home Hospital staff will also return the kit box and equipment to RACH nursing staff and ensure this is stored securely.

All My Home Hospital patients will have a hospital inpatient health record during the entire episode of care. All documentation from My Home Hospital services will be entered into the My Home Hospital health record.

The My Home Hospital medical team will contact the RACH as part of the daily ward round, will discuss the patient's progress with RACH staff and provide updates relating to their care, for example if a resident's usual medications need to be adjusted due to their acute illness.

The My Home Hospital care coordinator can be contacted at any time on 1800 111 644 with questions or concerns.

Observation and condition monitoring

My Home Hospital patients receive a physical visit from an RN at least once daily. Remote monitoring technology is used to assess a patient's condition in between physical visits. Observations recorded using this technology are immediately uploaded to My Home Hospital's Virtual Care Centre and flagged for review if outside of the patient's individualised parameters.

The equipment is provided and maintained by My Home Hospital and staff will provide clear instructions to the patient and RACH staff both in hard copy and verbally on how to use it during the first visit.

Patients or staff can also contact My Home Hospital care coordinator for assistance at **any time 24 hours a day, 7 days on 1800 111 644**.

In addition, as previously stated, my Home Hospital holds virtual daily ward rounds for all admitted patients to review their progress and make any necessary changes to their care.

Safety and quality requirements

My Home Hospital service providers are required to meet the National Safety and Quality Health Service Standards and standards such as those applying to registered health professionals.

My Home Hospital staff are aware that RACH are required to comply with the Strengthened Aged Care Quality Standards and the Code of Conduct for Aged Care. Furthermore, staff are aware that RACH providing services to NDIS participants are also required to comply with NDIS Code of Conduct and NDIS Practice Standards.

If there are any questions about how My Home Hospital and the RACH work together to meet the standards applying to each organisation, please speak with the My Home Hospital care coordinator.

Incident management

My Home Hospital is responsible for managing and formally reporting critical incidents, hospital-acquired complications and sentinel events to SA Health and has its own internal quality management system to respond to near misses, incidents or feedback received. All serious incidents or significant patient or family concerns are notified and documented in the Safety Learning System, in line with SA Health policy and practice.

If an aged care provider's staff member becomes aware of an incident or a near miss while the resident is admitted to My Home Hospital, please notify the My Home Hospital care coordinator on **1800 111 644** so they can continue to ensure resident and staff safety, identify any learning opportunities and fulfil any formal notification requirements.

My Home Hospital staff are aware that aged care providers have responsibilities under the aged care legislative framework with regards to management, prevention and reporting of near misses and incidents, including requirements as part of the Serious Incident Response Scheme. Providers may have additional obligations if they have residents in their care who are also NDIS participants.

As such, My Home Hospital staff onsite will report any concerns or potential hazards to RACH staff to ensure the safety of both staff and residents. In addition, the My Home Hospital care coordinator or doctor will ensure timely information is provided to the RACH staff of any incidents or near misses that they become aware of so that requirements can be met.

Escalation

Patient deterioration

In an emergency, call Triple Zero (000), after ensuring this is in alignment with the patient's goals of care or Advance Care Directive, and tell the call taker that the resident is a My Home Hospital patient. This means the ambulance service can contact My Home Hospital for any relevant information that will help with emergency care.

If it is not an emergency, please call My Home Hospital on 1800 111 644 at any time of the day or night if a patient becomes more unwell or to discuss their needs, regardless of the reason for admission.

The patient's condition will be assessed over the phone and a home visit may be arranged to provide further treatment. If required, My Home Hospital will arrange for the patient to be transferred to a physical hospital.

All plans for escalation will be developed and documented in the patient's care plan and will be in accordance with the patient's Advance Care Directive, if they have one.

Transfer to hospital

If a patient requires transport to a physical hospital, My Home Hospital can arrange and fund the transport. A clinical handover will be provided to the receiving hospital by the My Home Hospital medical staff.

Discharge

Handover of care on discharge from My Home Hospital

When the patient is ready for discharge, their usual GP will be contacted about any ongoing care or follow up requirements.

A discharge summary will be provided to the resident, the referrer, the resident's usual GP and the RACH within 24 hours of discharge.

Discharge medications

The discharge summary will include a full medication list, including notation of any changes. If required, My Home Hospital will also send the RACH an interim medication chart and any short-term medications that are required to support the resident between discharge and review by the resident's usual GP.

If required, a My Home Hospital clinical pharmacist can also liaise with the RACH's community pharmacy and ensure any changes are communicated and that additional medications are made available to the patient on discharge.

Access to post-acute services

My Home Hospital will arrange for referrals to any post-acute services or medical follow up as required. This information will be provided to the RACH and the GP in the discharge summary.

Feedback

My Home Hospital is committed to continuous service improvement and welcomes feedback about the service, including compliments, complaints, suggestions or advice.

If you would like to provide feedback please email Health.MyHomeHospital@sa.gov.au.

This inbox is monitored by the Department for Health and Wellbeing, Integrated Care Systems team Monday to Friday during office hours.

For non-urgent responses, a member of our team will contact you within the next three business days to discuss your feedback.

Contact My Home Hospital

If you are a referrer requiring further information about a current My Home Hospital referral or patient, please call the My Home Hospital care team on 1800 111 644.

For further information

More information about the My Home Hospital service is available at myhomehospital.sa.gov.au.

For more information about consent to medical treatment and healthcare, decision-making capacity and Advance Care Directives, please refer to:

- The SA Health Consent to medical treatment and health care website: www.sahealth.sa.gov.au/healthcaretreatmentconsent
- The SA Health Consent to medical treatment for health professionals website: www.sahealth.sa.gov.au/consenttomedicaltreatment
- The Advance Care Directive website: www.advancecaredirectives.sa.gov.au

My Home Hospital

For more information:

Integrated Care Systems

SA Health

Visit us online **myhomehospital.sa.gov.au**

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