Tele-geriatric Inpatient and Outpatient Service

Initiative Type

Model of Care

Status

Sustained

Added

19 March 2019

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08 June 2020

URL

https://clinicalexcellence.qld.gov.au/improvement-exchange/tele-geriatric-inpatient-and-outpatient-service

Summary

The project establishes an ongoing Tele-geriatric service for the ageing population within the Central West Hospital and Health Service (CWHHS) without the clients having to travel too far from home.

Key dates

Oct 2017

Jun 2018

Implementation sites

Central West HHS - Longreach Hospital, Metro South HHS – Princess Alexandra Hospital

Partnerships

Telehealth Support Unit, Healthcare Improvement Unit, Clinical Excellence Queensland

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Aim

To provide access to a Specialist Geriatrician from the Princess Alexandra Hospital (PAH) and support locally by the CWHHS Clinical Nurse (CN).

Benefits

- Timely access to a specialist assessment by Geriatrician without having to travel to the tertiary facilities.
- Future planning to help minimise functional decline and helping maintain independence as they age by supporting their physical, medical, psychological, cultural and social needs thus improving their quality of life.
- Education provided to families and carers, increasing their knowledge on progression or trajectory of the client's health, and also where they can find further information and support.
- The clinical staff such as General Practitioners (GP's), nursing and allied health are supported with prompt feedback in form of specialist letters outlining plan following consultation which has provided greater satisfaction and sense of achievement but importantly clinical outcomes have significantly benefited all clients and their families.

Background

The Central West region covers an area of 396,650 square kilometres, which is 23 per cent of the land mass of Queensland. This includes five major facilities and ten Primary Health Clinics. The CWHHS profile in comparison to the rest of Queensland is below the state average and the region is also classified as a socioeconomically disadvantaged area. Challenges within the CWHHS included the remoteness and distances between locations. The aging population is a critical factor affecting the HHS population and impacting on service provision and accessibility. An additional burden is placed on the CWHHS during April to September with an annual influx of traveling tourists; many of whom are elderly with health problems and co-morbidities.

Solutions Implemented

Services include: diagnosis of types of dementia, cognitive impairment management, polypharmacy with medication reviews, diagnosis and management of anxiety and depression, sleeping and behavioural management strategies, healthy bowel management, falls prevention strategies, carer stress and burnout plus future planning. The service has two allocated Telehealth mornings - Thursday 0945-1130hrs & Friday 0900-1130hrs. The service provides both inpatient and outpatient consultation and the service has also been utilised by the two local private residential care facilities within the Central West district.

Evaluation and Results

The expansion of the Tele-geriatric Service in our rural area has provided much needed care close to the home of the client, this also enables the client's families to be involved and not have to incur the associated costs with accessing tertiary level services from an isolated area. The Tele-geriatric Service supported by the CN Gerontology has been a great way for specialists in metropolitan areas to interact with the patients across the CWHHS and vice versa. Recommendations from the Geriatrician are evidenced based and up to date benefiting the clients, medication rationalization to ease burden on residents and reduce poly-pharmacy. Educational opportunities for both medical and nursing staff sitting in on Telehealth consultations with the clients.

Lessons Learnt

Early review by a Geriatrician provides clients and families with a diagnosis, recommendations and plan, plus useful interventions/strategies, all the while respecting their wishes and goals. This service is aiming to maximise client’s health and maintain their independence in their homes for as long as safely possible. Reversible causes can be investigated and treated, medications can be reviewed and adjusted, education provided and future planning can be implemented. Timely referrals for Allied Health can be done to assist with maintaining client’s independence and safety in their homes. Support and education can be provided to clients their families and also clinical staff on prevention strategies to help manage such issues as behaviour, sleep or communication. The service also provides support to family and carers, recognising the importance of accessing services such as Respite when they feel overwhelmed with the situation.

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