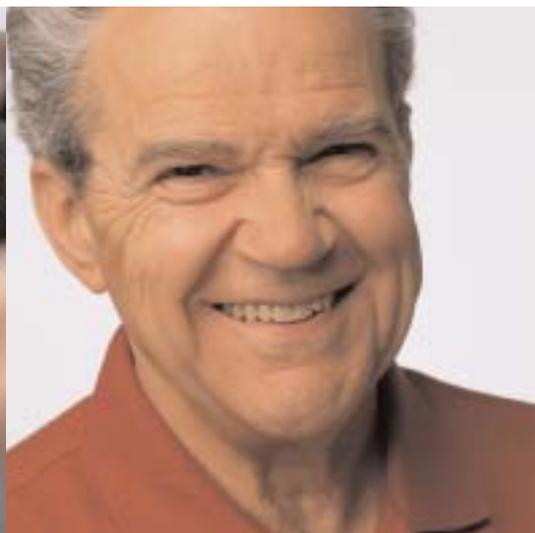
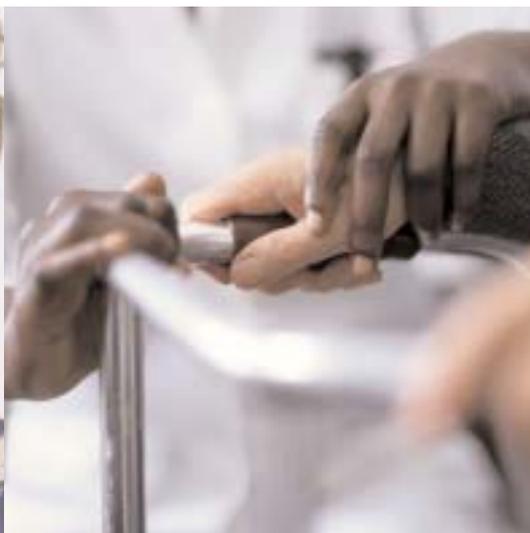
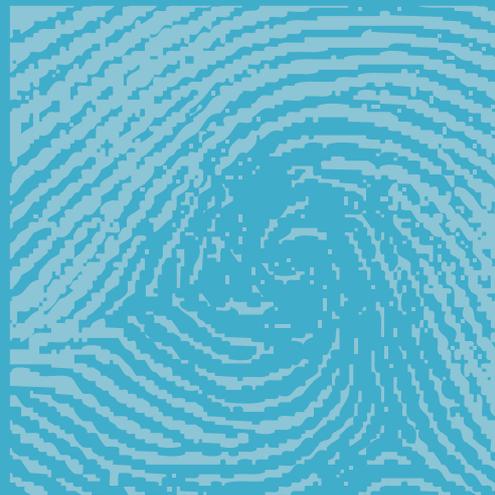


Improving care for older people

A summary of policy for Health Services



Improving care for older people
A summary of policy for Health Services

Published by the Metropolitan Health and Aged Care Services Division,
Victorian Government Department of Human Services, Melbourne, Victoria.

© Copyright State of Victoria, Department of Human Services, 2003.

This publication is copyright. No part may be reproduced by any process except
in accordance with the provisions of the Copyright Act 1968.

This document may also be downloaded from the Department of Human Services
web site at: <http://dhs.vic.gov.au/ahs/concare.htm>

(031011)

Authorised by the State Government of Victoria, 555 Collins Street, Melbourne.

Printed by Thaker Print, PO Box 517, Blackburn, Victoria 3130

Foreword from the Ministers

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

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

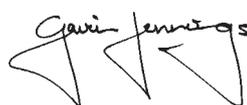
The Victorian Government, together with Health Services, has a clear responsibility for meeting the health care needs of the increasing number of older people. To address this challenge, we will need to fundamentally change the way we care for older people and alter our processes so that we can be more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

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

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

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

This booklet summarises a more detailed policy document, *Improving care for older people: a policy for Health Services*, which addresses these issues. We encourage you to read both this booklet and the detailed policy document, as together they present a practical vision for improved health and community care services for older Victorians.



Gavin Jennings MLC
Minister for Aged Care



Hon Bronwyn Pike MP
Minister for Health

Contents

| | |
|--|----|
| Foreword from the Ministers | i |
| A new approach to improving health care for older people | 1 |
| Why a new approach to the care of older people is urgently required | 5 |
| Victoria's population is ageing | 5 |
| Nearly half the number of people in our hospitals are over 70 now | 6 |
| Increased recognition of diversity | 7 |
| Greater emphasis on person-centred care | 7 |
| Understanding the complex needs of older people | 8 |
| The importance of a holistic approach to the health care of older people | 8 |
| Specific issues | 8 |
| Malnutrition | 8 |
| Functional mobility | 9 |
| Loss of skin integrity | 9 |
| Incontinence | 10 |
| Falls | 11 |
| Delirium and dementia | 11 |
| Medication | 12 |
| Supporting the maintenance of self-care | 13 |
| Depression | 13 |
| Governance | 14 |
| Ongoing training for health professionals | 14 |
| Improving the integration of services to older people | 17 |
| A risk-screening tool for use in Health Service settings | 17 |
| Assessment is critical | 17 |
| Working together to create care plans | 17 |
| Transition planning and coordination of care | 18 |
| Alternatives to hospital settings | 20 |
| Community interface | 20 |
| Supportive care in the community | 20 |
| Moving to residential care | 21 |
| Centres Promoting Health Independence | 21 |
| Practical tips for person-centred, intergrated care for older people | 25 |
| Improving care settings for older people | 25 |
| Emergency departments | 25 |
| Acute Care of the Elderly (ACE) wards | 25 |
| Sub-acute settings | 26 |
| Checklist for the workplace | 27 |
| Remembering carers in discharge – some prompts | 29 |
| Where to from here? | 30 |
| Glossary | 31 |
| References and additional information sources | 33 |

A new approach to improving health care for older people



A person-centred approach to care

A new policy paper from the Victorian Government outlines how a ‘person-centred’ approach to the acute and sub-acute care of older Victorians can benefit the whole community. The aim is to make sure that older people are being cared for in the appropriate setting for their individual situation, and to empower them and the people who care for them to be involved in decision-making.

This summary booklet outlines ways in which everyone can move towards more person-centred care of older people. It contains practical tips on getting started and examples of ‘policy in action’. This is just a glimpse of the issues covered in the larger document, so for a copy of the full paper please see – <http://www.dhs.vic.gov.au/ahs/concare.htm>

‘Working with older people is particularly rewarding to me because it draws on all my skills. It’s a privilege to become part of someone’s life, and I really enjoy seeing their confidence improve thanks to the problem-solving I can bring to their situation.’

Bridget, Mordialloc

The following principles underpin the policy outlined in this paper. These principles form the basis of practices and processes that address the fundamental issues for Victorian Health Services in providing care for older people.

Principle 1: Specific care issues for older people

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

Principle 2: Clinical governance responsibility

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

Principle 3: Involving older people and carers

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

Principle 4: Identifying people with additional care needs

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

Principle 5: Assessing care needs

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

Principle 6: Planning care

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

Principle 7: Transition planning and coordination of care

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

Principle 8: Hospital inpatient care

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

Principle 9: Health Service community-based programs

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

Principle 10: Relationships between Health Services and ongoing community support services

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

Principle 11: Older people awaiting long-term care options

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

Principle 12: Promoting health independence

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

‘As health care professionals, we enter the field with a genuine desire to help people, and one of the most rewarding things about our work is the relationships we form with our patients. That’s why person-centred care of older people makes so much sense to me. And by helping people receive the most appropriate health care for their own situation, we also help them remain part of the greater community.’

Helen, Fitzroy.

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

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



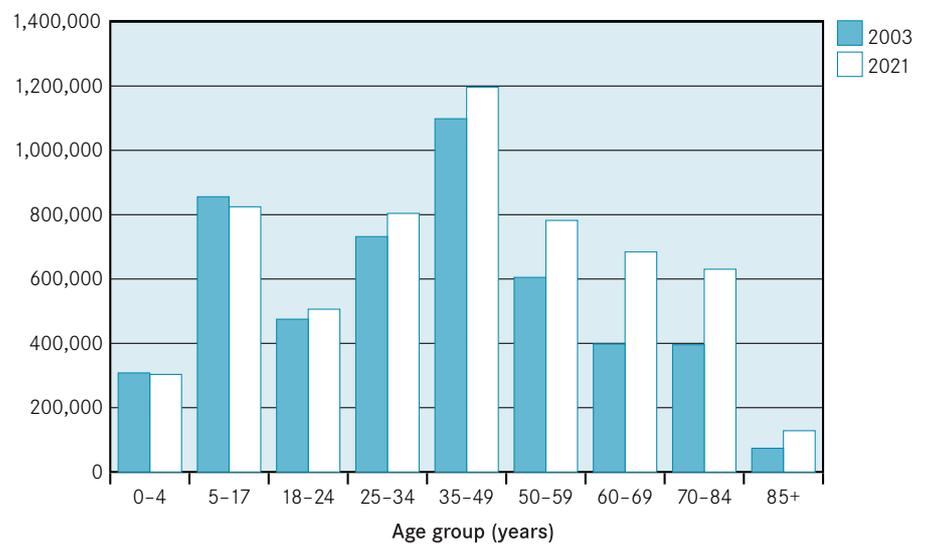
Why a new approach to the care of older people is urgently required

Victoria's population is ageing

Most Victorians are by now aware that our population is ageing. Interim projections from the Department of Sustainability and Environment (2003) predict a 19 per cent growth in the total Victorian population by the year 2021. The rate of growth for the 70–84 year age group during this time-frame will be substantially higher and is expected to be in the order of 59 per cent.

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

Figure 1: Victorian population structure projections 2003–2021



(Source: Department of Sustainability and Environment, 2003)

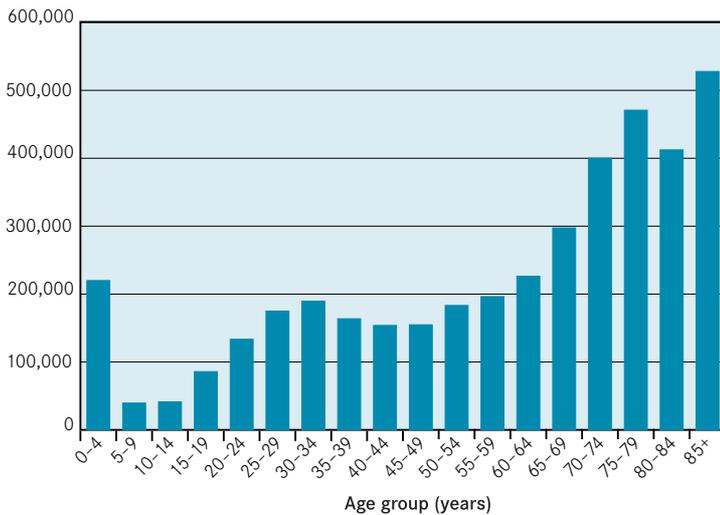
Nearly half the number of people in our hospitals are over 70 years old now

Older people use health services and community care services more frequently and for longer periods of time. The current situation in hospitals is that people over the age of 70 years use more than 46 per cent of all multiday patient stays. Naturally, as the percentage of older people in our society increases, patients will be older in every department of the hospital, except maternity and paediatrics. It therefore becomes part of every health care professional’s responsibility to consider older people as their main patient group.

People over 85 years of age (the group that will grow by 74 per cent in the next 20 years), are 4.2 times more likely to be admitted to hospital than people aged 70–74 years (Department of Human Services, 2001-02a). Figure 2 shows the use of public hospital beds by age group.

Figure 2: Public hospital bed days by age group 2001–2002

(excluding unqualified newborns)



(Source: Department of Human Services, 2001-02a)

Increased recognition of diversity

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

We have a responsibility to provide care that takes each individual's needs and preferences into account, including preferences based on religious beliefs, language or cultural background.

A number of older people have disabilities, including physical, intellectual, sensory and degenerative neurological diseases such as Multiple Sclerosis and Parkinson's disease. The interaction of disability with ageing and frailty, may create additional care challenges for Health Services to meet.

Greater emphasis on person-centred care

Health care professionals must be aware of, and understand, the specific care issues for older people and how to manage these issues in accordance with practice based on best evidence.

Because each person will present with a different and possibly complex health profile, health care planning should be person-centred in approach. This means that the goals of the older person and their carers, where appropriate, are the focus of the care plan.

Through involving older people in their own care, Health Services can better recognise and address issues that are central to the person's recovery, which in turn promotes health independence.

Carers, including family members and friends, are extremely important to person-centred care because the presence of a carer is often the significant factor enabling an older person to remain living at home (or return home).

Carers can often provide valuable knowledge about the older person's condition, previous illnesses, behaviour and attitude. Therefore, carers should be included in discussions about treatment, therapy and care options, with the older person's consent.

However, caring itself has consequences, and health care professionals need to be aware of the stress and difficulties that affect the carer when planning the transition from the hospital setting.

Person-centred care involves putting your patient and their carer at the centre of the care plan—involving them in decision-making and considering their needs.

Visit the website: on <http://www.dhs.vic.gov.au/ahs/concare.htm> to download the full policy paper and for more reference information.

Understanding the complex needs of older people

The importance of a holistic approach to the health care of older people

Older people are the main users of Health Services and this will continue into the future. As a natural result of ageing, they will often present with multiple co-morbidities and will be particularly susceptible to adverse events. Many older people are at risk of experiencing functional decline, such as malnutrition, decreased mobility, loss of skin integrity, incontinence, falls, development of delirium, problems with medication, poor self-care and depression while in hospital (see Specific issues, below).

Many older people living alone will need a high level of health care and support on a frequent basis, but not necessarily the specialist treatment and level of care that an acute hospital provides. These patient groups will require greater emphasis on care planning and coordination to make the move back home and remain there safely.

Treatment and care that is tailored to individual requirements in a holistic way includes consulting carers in the assessment and planning process. The needs of the older person and their carer should be considered when planning the transition back to the community. Also, awareness of the stress and difficulties that can affect carers, and offering support where appropriate (for example, through access to carer support centres) is important.

Specific issues

Malnutrition

As many as 40 per cent of older people admitted to hospital are already malnourished, and more than 60 per cent of older people are unable to maintain their nutritional status while in hospital (McWhirter and Pennington, 1994). This has been attributed to poor recognition and monitoring of nutritional status and inadequate intake of nutrients in the inpatient setting. Malnutrition is linked to diminished cognitive and physical performance and a reduced overall sense of physical and mental wellbeing.

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



Older people with complex care requirements must be provided with the kind of care that is suited to their individual needs.

Avoiding malnutrition

- Screening and early intervention are the key to managing malnutrition in older people in both the hospital and community settings. An assessment that examines the older person's ability to maintain their own nutritional requirements is advised, as it informs the older person's care plan.
- Older people need particular attention so that they receive adequate and appropriate nutrition and hydration while they are in hospital. While hospital meals are generally considered to be a 'hotel service', meals provided to older people during their hospital stay are an important part of care.
- Malnutrition may be the result of a swallowing disorder. Studies have shown that swallowing disorders may affect up to 10 per cent of hospitalised older people (Hudson et al., 2000).
- Meal scheduling, use of medications, swallowing, dental issues and changes in environment may affect appetite and nutritional intake. For people with dementia, the risk of nutritional deficit may be heightened in hospital when food is presented in unfamiliar circumstances or is not readily visible and recognisable.

Implementing a functional mobility program within the hospital has been shown to improve outcomes for older people by encouraging independence and activity. It may help to reduce the length of hospital stay for patients, facilitate a quicker recovery and save money for Health Services (Dorevitch et al., 2002).

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

Functional mobility

Hospitalisation and bed rest present a significant problem for older people. It has been found that up to 30 per cent of people aged over 70 years return home from a hospital stay with a reduced ability to perform the usual activities of daily living (Royal Melbourne Hospital, 2002). In addition, one in six become newly dependent in walking as a result of hospitalisation, with less than half of these people regaining their previous level of functioning six months after discharge from hospital (Mahoney et al., 1998).

Many older people will therefore, require periodic treatment or therapy for chronic conditions or increasing frailty, and may need additional supports to resume living in the community.

Loss of skin integrity

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

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

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

Incontinence

In Australia, regular incontinence affects one million people, of which 80 per cent are women (Department of Human Services, 2001a).

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

Reducing incontinence

- A person's clinical/medical status, medication, mobility, physical environment (for example, access to toilet facilities) and cognitive status can have an effect on their continence. It is important that older people receive appropriate assessment and interventions based on best evidence to prevent the onset of incontinence or to effectively manage existing continence issues.
- The use of an indwelling catheter (IDC) for managing incontinence is common in hospitalised older people, even though it is often inappropriate (Royal Melbourne Hospital, 2002) and has been found to be associated with the development of delirium, urinary tract infection, increased length of stay and increased mortality (Inouye et al. 1996; Riedinger et al., 1998; Palmer et al., 1994; Platt et al., 1982).



Visit the website: on <http://www.dhs.vic.gov.au/ahs/concare.htm> to download the full policy paper and for more reference information.

Falls

Falls and fall-related injuries in Australia caused 45,000 people over the age of 65 years to be hospitalised in 1998, averaging 11 days of hospital care for a total of 486,484 hospital bed days (Cripps and Jarman, 2001).

Falls are also one of the most reported incidents in hospitals, with 38 per cent of all patient incidents in Australia involving a fall (The Joanna Briggs Institute, 1998).

The estimated health care cost associated with falls among older Australians is more than \$406 million annually (Mathers and Penm, 1999). As the population continues to age, the number of people presenting with falls and fall-related injuries is projected to escalate (Sanders et al. 1999).

Preventing falls

- Patient management practices and physical environment should be assessed to eliminate risks. For example, monitor your environment to make sure that hallways are kept clear of obstructions to reduce the risk of falls.
- Health Services should work to provide education and information to ensure all staff, patients and carers are aware of the increased risk to older people of falls in hospitals.

Delirium and dementia

Delirium and dementia are the most common causes of cognitive dysfunction. Although delirium and dementia may occur together, they are quite different.

Delirium begins suddenly, causes fluctuations in mental function, and is usually reversible. Dementia begins gradually, is slowly progressive and is usually irreversible. Both delirium and dementia may occur at any age but are much more common among older people, because of age-related changes in the brain (Beers & Berkow, 2003).

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

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

Understanding delirium and dementia

- Given that dementia in older people is often under-diagnosed, it is important that people with cognitive impairment are identified early in their care, preferably on admission, and that the condition is actively managed.
- Some Health Services employ cognition nurses who provide ward staff with specialist support and education. Others provide separate, secure wards that have a higher nurse/patient ratio, a design that enables people with dementia to wander freely, has good access to toilets and high-low and low-low beds.
- Health Services are encouraged to implement practice based on best evidence to avoid or reduce the use of physical or chemical patient restraints, which have been shown to increase the risk of adverse events.

Medication

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

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

Reducing problems with medication

Health Services should ensure that:

- staff review the medication regimen of all older people at admission or presentation
- medical and nursing staff are educated about specific medication issues in relation to older people
- older people receive appropriate medication instructions and information to reduce errors when they return home
- staff initiate safe prescribing procedures to reduce the risk of adverse events and prescribing errors
- on discharge, a medication and treatment summary is provided to the person's GP.

Some Health Services have appointed a community liaison officer as a link to older people and carers when they return home. Others have a pharmacist, nurse or GP conduct post-discharge visits as part of discharge practice to help the older person avoid medication errors and comply with the medication regimen. It is also important that liaison occurs with the older person's GP about the person's medication regime on return to the community.

Processes used to reduce the risk of medication errors should be informed by the *National guidelines to achieve the continuum of quality use of medicines between hospital and the community* (Commonwealth Department of Health and Family Services, 1998) a copy of this document can be obtained at – <http://www.health.gov.au/haf/nmp/quality.htm>

Where possible, provide environments that are conducive to self-care – for example, adequate privacy for changing clothes, bathroom facilities that older people can use with easy open taps.

Recognising and treating depression produces better health outcomes for an older person. The Geriatric Depression Scale has been shown to be useful in detecting depression and, if appropriate, should be followed by a comprehensive assessment involving the older person and their carers.

Supporting the maintenance of self-care

Some older people may have difficulty attending to their own self-care as their frailty and degree of handicap increase. Hospitalisation may exacerbate these issues.

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

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

Dental and oral disorders are common among older people. Assistance with oral care should be offered, if appropriate.

Foot care issues, if not addressed, may result in infection or reduced ability to mobilise safely. Health Services should be aware of these issues and refer older people to the appropriate specialist when necessary.

Depression

Depression frequently occurs in older people when they face coming to terms with reduced and deteriorating physical health and mental functioning, grief over a decrease in their independence or when mourning the loss of a loved one. Also, as more older people are living alone, they may feel socially isolated and experience depression.

Older people in hospital suffering from depression may be particularly vulnerable when faced with a change to their condition or after a long period of hospitalisation, due to their often poor social support system. They are more likely to have a longer stay, be readmitted and, ultimately, be placed into residential care (Bula et al. 2001).

Governance

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

Ongoing training for health professionals

Lifelong learning and continuous development for health care professionals are essential components of good clinical governance. For health care professionals to provide effective care, they need to make sure that their own skills, knowledge and expertise are current.

Health Services have a responsibility to employ staff who are appropriately skilled and who understand the specific needs of older people, and to provide their staff with opportunities to extend their knowledge and experience.

Policy in action: Mrs Ryan

Background

Mrs Ryan came into hospital for a total hip replacement due to severe arthritis. She lived alone, was 76 years old and had already been diagnosed by the Cognitive, Dementia and Memory Service (CDAMS) as having early stage dementia. Mrs Ryan also had a hearing impairment. Mrs Ryan's main carer was her daughter who lived with her own family close by.

Assessment

When Mrs Ryan was admitted for surgery, her GP was informed of her admission. Mrs Ryan's daughter accompanied her to the hospital. Mrs Ryan was also risk screened (see page 17) – and, as she lived alone and was over 70, she returned a positive risk screen and was identified as needing a comprehensive assessment.

After a comprehensive assessment by an interdisciplinary team (and in conjunction with her daughter) the issues for Mrs Ryan in the inpatient setting were determined with the possibility of loss of skin integrity flagged, along with the risk of falls and the risk of delirium.

Nursing staff implemented a care pathway that included attention to nutrition, hydration, pain management and pressure injury prevention. An appropriate environment was provided and all staff were notified that Mrs Ryan had a hearing impairment and used a hearing aid. The social worker from the interdisciplinary team was nominated as Mrs Ryan's key worker and main contact person for her daughter and GP.

After the operation

Mrs Ryan's key worker arranged for Mrs Ryan's daughter to be present following surgery. Mrs Ryan and her daughter were informed about the possibility of delirium after surgery and what this would mean for them both.

After the operation Mrs Ryan became very confused and a geriatrician was consulted. A delirium care pathway was used and with additional pain relief her delirium settled.

When Mrs Ryan became well enough she was transferred to the rehabilitation ward where she commenced a rehabilitation program. Her GP was informed of the transfer and took part in discharge planning meetings via conference phone. Mrs Ryan, her daughter and a member of the Health Service's community-based therapy team were also involved in these meetings.

Mrs Ryan improved rapidly and was discharged home under the care of her daughter. Her rehabilitation program continued at home for 10 days through the Health Service's community-based therapy team. Once Mrs Ryan was able to mobilise more easily, she continued her physiotherapy and hydrotherapy at the nearest Centre Promoting Health Independence twice per week for a further four weeks.

Her wound was checked at the centre each week and her GP visited her at home fortnightly.

Result

Within six weeks of returning home Mrs Ryan resumed her previous level of independence and, following the surgery now has less pain and improved mobility. She has been discharged from the community-based therapy service and referred to an arthritis self-help group run the nearest Centre Promoting Health Independence. She is able to attend a weekly hydrotherapy class at the centre with the assistance of her daughter. She also has access to the CDAMS clinic at the centre. The key worker introduced Mrs Ryan and her daughter to the carer's support service at the Centre Promoting Health Independence. Through this service Mrs Ryan's daughter was provided with information on services that she can access should she require additional support in caring for Mrs Ryan.

'We involve the carers in the decision-making process and they really appreciate it – because they can feel quite put-upon and left out, but once you involve them, the whole process just flows really smoothly. They take on the responsibility for the decisions you've come to together.'

John, Bairnsdale.



Improving the integration of services to older people

A risk-screening tool for use in Health Service settings

A risk-screening tool, which flags potential discharge issues, has been developed for the Department of Human Services by Thomas and Associates (1998) as part of the Effective Discharge Strategy. It is a four-question tool that is simple and quick to administer. It should be used as a minimum standard for risk screening all people for existing and potential supportive care requirements. This tool comprises four questions.

- Is your patient likely to have self-care problems?
- Does your patient live alone and is over 70 years?
- Does your patient have caring responsibilities for others?
- Has your patient used services before admission?

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

The department will work with Health Services to expand and validate this tool so that it also identifies those at risk of adverse health outcomes.

Assessment is critical

Older people often have co-morbidities that require a holistic, problem-solving approach to their care. To achieve this, it is important that they are first risk screened and, if the risk screen is positive (and they are over 70 years of age), that they receive a comprehensive assessment.

Assessments should be linked to care plans with appropriate interventions where risks and care needs are identified. Assessments, plans and interventions should include attention to specific age-related issues, such as the risk of malnutrition, decreased functional mobility, loss of skin integrity, incontinence, falls, the development of delirium, problems with medication, poor self-care and depression.

Working together to create care plans

A comprehensive assessment of an older person is most successful when conducted by a team. It is also important that the person and their carer is involved in the development of their interdisciplinary care plan, including planning for their transition back to the community, and that they have their care coordinated through a single point.

Where the person has previously received ongoing community support services, it is important that the provider of these services and the person's GP are notified and involved in care planning, if appropriate.

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

Transition planning and coordination of care

The care of people who move across different levels of the health system needs to be coordinated to avoid delays and provide a smooth continuum of care. People assessed as having complex care needs should have a single person coordinate their care by working with them and their carers, where possible.

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

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

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

Health Services should use the client information, privacy and consent PCP Service Coordination Tool Templates (SCTTs) for coordinating the care of people who require ongoing community support services and are moving back to the community.

Any assessments or other relevant information about the person can be included with the SCTTs and passed to ongoing community support providers with the person's consent.

At the time of transition from the hospital, it is important that the person's discharge summary is sent to their GP and other relevant care providers (such as the person's residential care provider).

Policy in action: Mr King

Background

Mr King was 85 years old and lived at home with his wife who was his main carer. He had a stroke five years ago and needed assistance with self-care and with mobilising. Mr and Mrs King received Meals-on-Wheels five days per week and home care once per fortnight from the Home and Community Care (HACC) service provided by his local council.

Mr King came to the Emergency Department with a painful right foot and after a short wait in a quiet area in Emergency, his foot was X-rayed and showed no fracture. Mr King was risk screened – this was positive, as he has self-care problems and currently receives community services.

Assessment

Because of his positive risk screen, Mr King had a comprehensive assessment in the Emergency Department. This assessment showed that Mr King's wife was not coping with his care, and was showing signs of carer stress. Because of his reduced mobility he needed assistance in showering and dressing. He also had some urinary incontinence, especially during the night.

He was referred to the Care Co-ordination team to appoint a case manager and arrange the following services:

- Sub-acute community-based therapy (physiotherapy and occupational therapy).
- Referral to a continence clinic.
- Referral to the Post-acute Care (PAC) service for additional personal care to meet these needs while awaiting an increase in the level of HACC services provided.

Outcomes for Mr King and his wife

Mr King was able to return home the same day. Mr King's GP was notified and linked with his case manager. His PAC service began the next day, and continued until the services were picked up by HACC providers. The sub-acute community-based therapy team visited Mr King at home where they undertook assessments and commenced treatment. The carer stress issues for Mrs King were addressed, and a hospital admission avoided.

Alternatives to hospital settings

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

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

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

Health Services should continue to identify conditions that can be safely managed in a person's home as an alternative or in addition to an inpatient stay.

Community interface

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

Health Services' community-based programs can serve to prevent hospital admission, re-admission and improve health outcomes by ensuring adequate treatment and supports are available to enable people to reach their optimal level of functional independence.

Supportive care in the community

Health Services may arrange and provide additional, time-limited community-based supports for older people who no longer need treatment services but do need a range of other services to assist them to return to living independently in the community. These supports can also be used to prevent unnecessary admission to hospital.

Short-term supportive care at home can include assistance with personal care, meals, some nursing and other support services.

Health Services currently arrange supportive services through the PAC program. Approximately 8 per cent of people discharged from Health Services access additional community care through the PAC program (Department of Human Services, 2001-02a) and, of the people using PAC services, around 44 per cent are over the age of 70 (Department of Human Services, 2001-02b). These short-term community supports can be used to assist older people to recuperate and prevent functional decline until more appropriate long-term community care options are available, usually for a period of up to 28 days.

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

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

Moving to residential care

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

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

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

To address this issue, some Health Services have implemented short-term alternatives such as interim care, which provides temporary support and active management for older people who have completed their acute or sub-acute care.

Centres Promoting Health Independence

Older people often require access to specialist assessment and treatment and a variety of support services to be able to regain or maintain their independence in the community. Centres Promoting Health Independence will be a resource to enable people (with a focus on older people) to receive the treatment and care services they require in the community.

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

Centres Promoting Health Independence will work collaboratively with all Health Services in their region to support the delivery of quality specialist services.

Clinical expertise will include inpatient sub-acute care, centre-based and home-based services (cognitive, dementia and memory services), continence clinics, falls and mobility clinics and mobile outreach services. These specialist services will provide health care professionals with access to a wider support network for the management of people with complex needs.

Such arrangements already exist at most extended care centres and at some major sub-acute facilities. The refocusing and further development of these sites will promote the integration of appropriate services. These co-located services should develop a high profile as Centres Promoting Health Independence.

Policy in action: Mrs Martino

Background

Mrs Martino, was 73-years-old and lived independently at home. She was admitted to hospital following a fall at home. She had a past history of hypertension, congestive cardiac failure, osteoporosis and a peptic ulcer. On presentation to the Emergency Department she was risk screened and, as she lived alone and was over 70 years of age, was found to be at risk of having potential supportive care requirements on discharge from hospital. This flagged the need for a comprehensive assessment. Mrs Martino's first language was Italian and required an interpreter.

Assessment

A comprehensive interdisciplinary assessment was undertaken with the aid of an interpreter. This identified that Mrs Martino had significant issues with her medication management. Mrs Martino was admitted directly to the Geriatric Evaluation and Management Unit (GEM). Mrs Martino's GP was notified of her admission and consulted for background information. He was enthusiastic about being actively involved with her discharge plan.

Mrs Martino and her family worked with the interdisciplinary team to develop a therapy program to assist in improving her balance and to general mobility.

A full review of her medication revealed polypharmacy and that Mrs Martino was confused about what medications to take and when.

Following the review of her medication, the pharmacist explained, with the aid of an interpreter, what her medication was for and how to take it correctly using a dosette box.

Care plan in place

Assessment by the occupational therapist and social worker found Mrs Martino able to live independently at home, however after a home visit, some safety concerns with showering were identified.

With her consent, a meeting was held with Mrs Martino, her brother, the team and an interpreter. Her GP, while keen to be involved in discharge planning, was unable to attend in person so was linked in by phone. The team conveyed the need for assistance with self-care at home for a short period to help her become completely independent and safe with respect to showering.

The post-acute care (PAC) program arranged for Mrs Martino to receive this additional support along with supervision of her medication. She was also referred for HACC services (including ongoing supervision of her dosette box by the Royal District Nursing Service). A care plan was developed and clarified with her GP.

Result

Mrs Martino was given the details of the care plan including information about the services put in place for her, contact details and start dates.

Mrs Martino was discharged home and received services from PAC for 23 days following her discharge from hospital. HACC was then able to take on this care and she made fortnightly visits to her GP.

Follow-up phone calls using the telephone interpreting service were made to ensure Mrs Martino's services had started and to check how she was getting on. The team was later advised that she had progressed well and had resumed her previous level of independence.

'People sometimes think of aged care as a specialist area but in our busy Emergency Department many of our patients are older people. So we're all actually working in aged care – that's just the fact of the matter.'
Maria, Collingwood.



Practical tips for person-centred, integrated care of older people

Improving care settings for older people

Hospitals have generally been designed, built and staffed to maximise efficiency, which does not necessarily produce the best care model for older people. We can improve the inpatient experience for older people by:

- designing areas that older people can navigate easily and areas where they can eat and socialise.
- accommodating the fact that older people may have cognitive impairment, hearing loss, a visual deficit and/or mobility problems, through signage and mobility aids (eg. non-slip floors, rails).
- taking into account the Positive Ageing Foundation's work on the principles and elements that contribute to 'age friendly hospitals' (Hegarty & Griffiths: 2002). For further information go to www.positiveageing.com.au

Emergency departments

All staff should be trained to have a strong awareness of the needs of older people, so they can plan work practices and interaction accordingly.

- As much as possible, lessen the waiting time older people spend on trolleys or in noisy emergency departments. Some Health Services have developed processes whereby older people are provided with access to specialised inpatient areas. Other Health Services have provided older people with quiet areas in the emergency department where they can wait, and where staff can provide timely supervision and monitoring of care.
- Create aged care teams, and place gerontic clinical nurse specialists or geriatricians in the emergency department.

Acute Care of the Elderly (ACE) wards

- Some Health Services have configured an 'Acute Care of the Elderly' (ACE) ward. Practice and research evidence suggests that ACE units improve functioning and reduce the need for residential care placement.
- The staff complement of an ACE ward is different from the usual staffing of a general medical ward, with a higher ratio of allied health professionals. In these wards, early specialist intervention by a geriatrician and allied health staff enables the treatment of older people with an acute illness while preventing functional deterioration in those with complex health care needs.
- It is recognised that not all Health Services are able to reconfigure their wards into the ACE model. However, it is important that Health Services move to establishing an ACE focus in all wards through the availability of the appropriate staffing mix and settings for acutely ill older people with complex health care needs.

Sub-acute settings

- Sub-acute care spans both hospital and community settings. When older people and carers, inpatient staff, home-based staff and centre-based staff have a close working relationship, the integration of therapy from hospital to home is improved. Ideally, staff should move between care settings to improve their understanding of the issues relating to the integration of services.
- Centre-based rehabilitation should be co-located with inpatient services or other like services (such as community health services and/or health precincts) to encourage service integration, and shared administration and overhead costs.
- The provision of consultation liaison psychiatry is important in sub-acute settings, given the high levels of depression and anxiety among people with chronic illness.

Checklist for the workplace

- Nominate a **clinical champion** to improve care for older people.
- Identify staff awareness levels relating to **unique factors placing older people at risk** of injury and adverse events.
- Audit your physical environment** to identify potential safety concerns/issues relevant to older people's needs.
- Establish a working party** to investigate how **older people-friendly** your environment is.
- Implement processes to **reduce the risk of falls** (such as electing a staff member to monitor the environment so, for example, hallways and walkways are kept clear of obstructions at all times).
- Identify whether your staff know the **difference between multi-disciplinary and inter-disciplinary care**.
- Allocate a **care coordinator** for people with complex care needs.
- Establish a **GP notification system** for patient admissions and discharges.
- Be sure to **notify ongoing community support providers** about older people's entry to your service and their anticipated length of stay.
- Encourage **GPs to be involved** in and use the enhanced primary care case conferencing medicare benefit schedule items.
- Introduce a **discharge checklist** to be used when planning discharges involving older people and their carers.
- Invite PCP representatives to conduct an **information/Q&A session** with your staff.
- Always use **plain language** when talking to the older person about their illness, prognosis, treatments, medication and care management.
- Provide the older person with **information about any community-based services** that they may have been referred to.
- Ensure that the older person has a **contact name and 24-hour contact number** if they have any issues post-discharge home.
- Make sure that older people who are discharged from hospital are **contacted to see how they are managing** and to check how any services that they may be using are working out.
- Develop a brochure explaining how people can manage and **be involved in their own care with their nominated carer**.
- Run focus groups with older people who have used your services to **get their feedback**.
- Distribute results of the **patient satisfaction monitor** (relating to care of older people) to your staff.

Remembering carers in discharge – some prompts

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

Have you identified if the patient is a carer, has a family carer or will need one on discharge?

If the patient is a carer...

Have you discussed whether:

- the person(s) they care for has adequate alternative care arrangements while the carer is in hospital
- they have any concerns about how they will manage their care responsibilities on discharge and what impacts these may have on their recovery
- additional supports may be required to support their caring responsibilities and recovery on discharge?

If the patient has/will have a carer...

Have you talked/discussed with the carer about:

- how confident and able they feel about their caring responsibilities after discharge
- their own health, emotional concerns or other issues that arise from or affect their caring (eg poor health; work or other family commitments; grief reactions, stress or intimacy issues)
- the supports they may need from other family members or services after discharge (eg respite, carer education, assistance with household tasks, equipment)
- discharge arrangements with the carer (date, time, transport) and given 24hr notice about discharge?

Have you provided the carer with...

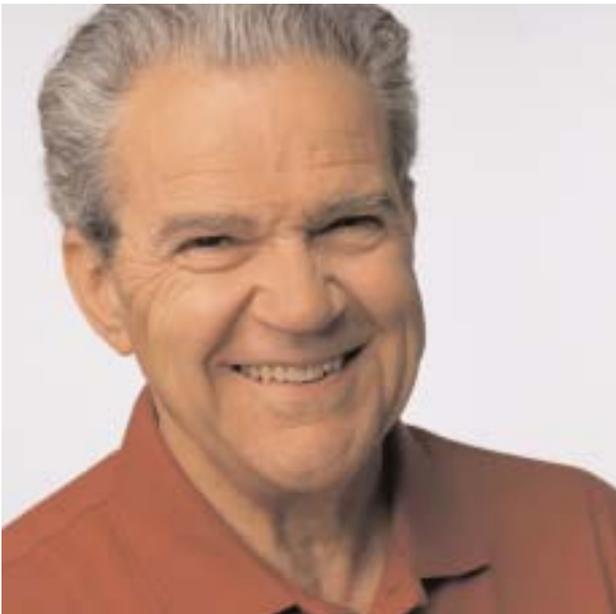
- service information and made referral (eg regional carer service) to address carer support needs
- plain language information addressed to the carer about the patient's illness, prognosis, treatments, medication and care management
- contact name and 24 hr contact number if they have worries post discharge
- a follow-up date when they will be contacted to see how they are managing and services working out?

Where to from here?

The government is committed to helping Health Services to put this policy into action and an implementation plan is being developed. More details are available on the following website – <http://www.dhs.vic.gov.au/ahs/concare.htm>

This will be updated as the implementation strategies are rolled-out. Why not make the website one of your ‘bookmarks’.

We look forward to working with you into the future, as we respond to the issues associated with an ageing population together.



Glossary

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

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

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

Effective Discharge Strategy (EDS): the strategy was funded by the Department of Human Services for a period of 5 years from 1998/1999 to improve discharge practices from public hospitals.

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

Geriatric Evaluation and Management (GEM): involves the sub-acute care of chronic or complex conditions associated with ageing, cognitive dysfunction, chronic illness or disability.

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

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

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

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

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

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

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

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

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

References and additional information sources

- Allman, R., Goode, P., Burst, N., Bartolucci, A. & Thomas, D. (1999) 'Pressure ulcers, hospital complications and disease severity: impact on hospital costs and length of stay', *Advances in Wound Care*, 12(1):22–30.
- Australian Society for Geriatric Medicine. (1997) 'Position statement no. 6: Nutrition in the elderly', *Australian Journal on Ageing* 16(4): 174–8.
- Beers, M.H. and Berkow, R. (2003) *The Merck Manual of Geriatrics*, retrieved on 25 June 2003. <http://www.merck.com>
- Bula, C., Wietlisbach, B.A., Burnand, B., Yersin, B. (2001) 'Depressive symptoms as a predictor of 6-month outcomes and services utilization in elderly medical patients', *American Medical Association*, 161: Nov 26, p. 2609.
- Commonwealth Department of Health and Ageing (2002) *List of Aged Care Services (web page)*, Ageing and Aged Care Division, Department of Health and Ageing. Retrieved on 20 December 2002. <http://www.health.gov.au/acc/rescare/servlist/servlist.htm>
- Commonwealth Department of Health, Housing and Community Services (1991) *Aged Care Reform Strategy mid-term review 1990–1991*, Discussion Papers, Canberra: AGPS 1991, p. 337.
- Commonwealth Department of Health and Family Services (1998) *National guidelines to achieve the continuum of quality use of medicines between hospital and the community* (in conjunction with the Australian Pharmaceutical Advisory Council), Canberra.
- Continenence Foundation of Victoria (2000) *Annual Report*, Melbourne, Victoria.
- Cripps, R. & Jarman, J. (2001) *Falls by the elderly in Australia: trends and data for 1998*, (Injury Research and Statistics Series), Australian Institute for Health and Welfare, Adelaide.
- Department of Human Services (1995–1996) *Victorian Admitted Episode Dataset 1995–1996*, Melbourne, Department of Human Services, Victoria.
- Department of Human Services (1996), *Victoria's mental health service: the framework for service delivery—aged persons services*, Melbourne, Aged Care, Community Care and Mental Health, Department of Human Services, Victoria.
- Department of Human Services (1997), *Rehabilitation into the 21st Century: a vision for Victoria*, Melbourne, Department of Human Services, Victoria.
- Department of Human Services (2001 a), *Improving continence care for Victorians. Position paper*, Melbourne, Department of Human Services, Victoria.
- Department of Human Services (2001 b), *Primary Care Partnerships—better access to services: a policy and operational framework*, Melbourne, Department of Human Services, Victoria.

Department of Human Services (2001-02a) *Victorian Admitted Episode Dataset 2001-2002*, Melbourne, Department of Human Services, Victoria.

Department of Human Services (2001-02b) Unpublished Post Acute Care project accountability reports 2001-02, Melbourne, Programs Branch, Department of Human Services, Victoria.

Department of Human Services (2002a) *New directions for Victoria's mental health services*, Melbourne, Mental Health Branch, Department of Human Services, Victoria.

Department of Human Services (2002b) *Victorian State Disability Plan 2002-2012*, Melbourne, Disability Services Division, Department of Human Services, Victoria.
<http://www.dhs.vic.gov.au/disability>

Department of Human Services (2002c) *Department of Human Services Bed Census, Hospital Demand Management Strategy*, Retrieved 30 April 2003.
<http://www.health.vic.gov.au/hsr/index>

Department of Human Services. (2003a) *Hospital Admission Risk Program (HARP) Integrated care for clients with complex care needs working party report*, Melbourne, Hospital Demand Management Strategy, Department of Human Services, Victoria.

Department of Human Services. (2003b) *Victorian Patient Satisfaction Monitor*. Retrieved 30 April 2003. <http://www.dhs.vic.gov.au/ahs/qualperf.htm>

Department of Human Services (2003c) *Evaluation of the Interim Care Program*, Melbourne, Continuing Care Section, Department of Human Services, Victoria.

Department of Infrastructure (2000) *Victoria in the future overview: the Victorian Government's population projections 1996-2021*, Research Unit, Melbourne, Department of Infrastructure, Victoria.

Department of Sustainability and Environment (2003) Interim population projections, based on 2001 census, (to be published), Research Unit, Melbourne, Department of Sustainability and Environment, Victoria.

Dorevitch, M, Hancock, A and Nall, C (2002) *A&RMC functional maintenance program: preventing functional decline in the preventing functional decline in the elderly during acute hospitalisation*. Retrieved on 30 April 2003.
http://www.health.vic.gov.au/older/session3/3b_armc.pdf

Hegarty D & Griffiths C, (2002) *To be or not to be an 'Age Friendly Hospital'*, Positive Ageing Foundation of Australia, Perth (unpublished paper).
<http://www.positiveageing.com.au>

Hudson, H.M., Dauber, C.R. & Russell, H.M. (2000) 'The interdependency of protein-energy malnutrition, ageing and dysphagia', *Dysphagia*, 15: 31-38.

Inouye, S. & Charpentier, P. (1996) 'Precipitating factors for delirium in hospitalised elderly persons: predictive model and interrelationship with baseline vulnerability', *Journal of the American Medical Association*, 275(11): 852-857.

Joanna Briggs Institute. (1997) Pressure Sores–Part 1, *Best Practice: evidence-based practice information sheets for health professionals*. 1(1).

Joanna Briggs Institute. (1998) 'Falls in hospitals', *Best Practice: evidence-based practice information sheets for health professionals* 2(2).

Jorm, A.F. & Henderson, A.S. (1993) *The problem of dementia in Australia* 3rd edition, (Aged and Community Care Service Development and Evaluation Reports, No.6) Canberra: Australian Government Publishing Service.

Lincoln Gerontology Centre (2002) *Victorian Aged Care Assessment Program evaluation*, Bundoora, Melbourne, p. 41 for the Department of Human Services, Victoria

Luk, J.K.H., Or, K.H. & Woo, J. (2000) 'Using the Comprehensive Geriatric Assessment technique to assess elderly patients' *Hong Kong Medical Journal*. 6(1):93-8

Mahoney, J., Sager, M. & Jalaluddin, M. (1998) 'New walking dependence associated with hospitalisation for acute medical illness: incidence and significance' *Journal of Gerontology: Med Sci* 1998.

Mathers, C. & Penm, R. (1999) *Health system costs of injury, poisoning and musculoskeletal disorders in Australia 1993–1994*, (Health and Welfare Series No 6), Canberra, Australian Institute of Health and Welfare.

McWhirter, J.P. and Pennington, C.R. (1994) 'Incidence and recognition of malnutrition in hospital' *British Medical Journal*. 308(6934):945-8

North Western Health (1999) *Hospital in the Home costing study*, Clinical Epidemiology and Health Service Evaluation Unit, Melbourne (for the Department of Human Services)

Palmer, R., Landefeld, C., Dresevic, D., Kowal, J. (1994) 'A medical unit for the acute care of the elderly', *Journal of the American Geriatrics Society* 1994;42:545-552.

Perneger, T., Heliot, C., Rai, A., Borst, F., Gaspoz, J. (1998), 'Hospital acquired pressure ulcers'. *Archives of Internal Medicine* 1998;158:1940.

Platt, R., Polk, B., Murdock, B. & Rosner, B. (1982), 'Mortality associated with nosocomial urinary tract infection'. *New England Journal of Medicine* 1982;307:637–642.

Productivity Commission (2002) Attachment 12A, Table 12A.8, *Report on Government Services* 2002. Attachment 12A, Table 12A.8, Melbourne.

Riedinger, J., Robbins, L. (1998) 'Prevention of iatrogenic illness: Adverse drug reactions and nosocomial infections in hospitalised older adults', *Acute hospital care* 1998;14(4):681.

Royal Melbourne Hospital (2002) *Evidence based guidelines: prevention of functional decline in elderly patients*, Clinical Epidemiology and Health Service Evaluation Unit, Melbourne

Rudd, A. and Wolfe, C. (1997) 'Randomised controlled trial to evaluate early discharge scheme for patients with stroke' *British Medical Journal*, 315(7115): 1039-44.0

Sach, J. and Associates (2001) *Sub-acute services strategic directions Victoria*, Report to the Department of Human Services, Victoria. Retrieved 30 April 2003. <http://subacutecare.health.vic.gov.au/>

Safety and Quality Council (2002) *Second national report on patient safety: improving medication safety*. Canberra, Commonwealth Department of Health and Ageing.

Sager, M., Franke, T., Inouye, S. et al. (1996) Functional outcomes of acute medical illness and hospitalisation in older persons. *Archives of Internal Medicine*;156:645-652.

Sanders, M., Nicholson, G. & Ugoni, A (1999) 'Health burden of hip and other fractures in Australia beyond 2000: projections based on the Geelong osteoporosis study', *Medical Journal of Australia*, 170:467-70

Schnelle, J.F. and Smith, R. (2001) *Annals of Internal Medicine*. 135 (8, part 2):752-8

Starey, N (2001) *What is clinical governance?* Retrieved 28 January 2002

<http://www.evidence-based-medicine.co.uk/ebmfiles/WhatisClinGov.pdf>

Sullivan, D.H. & Walls, R.C. (1994) 'Impact of nutritional status on morbidity in a population of geriatric rehabilitation patients', *Journal of the American Geriatrics Society*. 42: 471-7.

Thomas, D., Zdrowski, C., Wilson, M., Conright, K., Lewis, C., Tariq, S., et al. (2002), 'Malnutrition in sub acute care' *American Journal of Clinical Nutrition* 2002;75:308-13.

Thomas, S. and Associates (1998) *Report of the development of a risk screening tool for services needs following discharge from acute care*, Melbourne, Department of Human Services, Victoria

Victorian Office of Multicultural Affairs (2002) *Valuing cultural diversity*, Melbourne, Department of Premier and Cabinet, Victoria. <http://www.voma.vic.gov.au>.

Victorian Office of Multicultural Affairs (2003) *Improving the use of translating and interpreting services: a guide to Victorian Government policy and procedures*, Melbourne, Department of Premier and Cabinet, Victoria.

Visit the website:<http://www.dhs.vic.gov.au/ahs/concare.htm> to download the full policy paper and for more reference information.

