Entry Cover Sheet

Excellence in Innovation

The Hawke's Bay health system is transforming service delivery in ways which require us to think and work differently, to innovate and continuously improve. This award recognises those initiatives which have significantly changed the way we work with patients, their whānau, within our teams and with others.

Entrants must complete all sections below:	
Title of entry **Maximum of 70 characters** Be specific, eg "Reducing smoking rates for pregnant women". Title length must not exceed 70 characters.	ORBIT's St John Frailty Pathway- improving experience for frail older people.
Synopsis of entry **Maximum of 150 words** A brief paragraph providing an overview of your entry. Synopsis must not exceed 150 words.	The ORBIT team is a rapid response allied health team based at the Emergency Department (ED), and Acute Assessment Unit (AAU), of the hospital providing community outreach. ORBIT's focus is to prevent unnecessary admission to hospital for frail older people. The ORBIT St John Frailty Pathway was developed in June 2016 with the aim of providing urgent, interprofessional input for frail older people, seen by paramedics, who do not require hospital treatment or medical assessment. The focus is on providing assessment in the home to negate the need for transport to the ED. Negating the need for frail people to be transported to ED will lead to better outcomes for patients and less pressure on the Emergency Department and Acute Hospital. ORBIT also accept referrals for those displaying evidence they are not coping at home so that earlier intervention can be provided.

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Name of organisation/s **Is entry submitted on behalf of one or a number of organisations?** It is very important that you describe who is involved in this entry. This information is used in promotional materials, acknowledgements and inscribed onto awards, plaques and certificates.	This work is a collaboration between the engAGE ORBIT team (HBDHB) and St John Ambulance.

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Contact person Name of person/s who can be contacted in regards to this entry.	Sarah Shanahan
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Phone of contact person/s.	027 323 3193

APPROVAL SECTION for Hawke's Bay District Health Board applications		
Service Director entry review and endorsement	Name: Justin Lee Signature: _____ Date: 27/7/17	
Executive Manager entry review and endorsement	Name: Sharon Mason Signature: S Mason Date: 27/7/17	

APPROVAL SECTION for Primary Care / NGO Organisations applications		
Your organisation's CEO or GM entry review and endorsement	Name: _____ Signature: _____ Date: _____	

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Your organisation	The ORBIT team is part of the engAGE Service, part of the DHB's Older Persons Service. engAGE also encompasses the engAGE Community MDTs and Intermediate Care Services. The engAGE team is made up of Team Leader and Administrator and 16 Allied Health Professionals (Physiotherapists, Social Workers and Occupational Therapists). This team works interprofessionally and has close links with other DHB services (Gerontology CNS, Geriatricians, District Nursing, Clinical Pharmacist Facilitators, Older Persons' Mental Health, NASC HB). We collaborate with community health services - General Practice staff, Home Based Support Services and Age Related Residential Care Providers. Our vision is that "older people in Hawke's Bay are creatively engaged to achieve their well-being goals". Our mission is to "work in partnership with the older person, their whānau, and the community, to provide a seamless, responsive service that can be tailored to individual need. The older person will be heard and respected and their right to choice and dignity will always be upheld. We will strive to achieve equity in our community". We live the values of the Hawke's Bay Health Sector and have developed associated actions and outcomes to show how we apply these values to our work with older people.
Excellence in Innovation	<u>ORBIT:</u> Rapid response interprofessional allied health team (Physiotherapy, Occupational Therapy, and Social Work). The aim of ORBIT is to provide older people in ED/AAU/the community with a comprehensive interprofessional assessment, and treatment plan at a time of acute change in function due to illness or injury. ORBIT's interprofessional approach negates the need for multiple disciplinary consultations meaning the older person does not need to repeat their story and leading to better continuity for patients and families.

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ORBIT provides a holistic assessment of a person's social, functional and mobility status, including essential transfers, falls risk, and cognition, as indicated, and brief intervention (1-2 visits) to address the issues identified in collaboration with family, care agencies etc. This is achieved through:

- Assessment of equipment needs and provision of short term loan, or permanent equipment, as indicated (e.g. shower stools, raised toilet seats, etc.).
- Assessment of social support needs and arrangement of packages of care from NASC Hawke's Bay or ACC.
- Onward referral to appropriate services (e.g. engAGE Community multidisciplinary, community services, outpatient services, Gerontology CNS).
- Provision of information on a wide range of services (e.g. WINZ, meal deliveries, medical alarms, exercise groups, Age Concern, transport options, etc.).

Purpose of the ORBIT Frailty Pathway for St John:

The goal of St John referring to ORBIT is to negate the need for some frail older people to be transported to ED or to intervene before a person reaches crisis point.

Initial meetings with St John staff revealed that paramedics sometimes bring older people to ED who could remain at home if a rapid response service was available. They often see people in their homes who display signs of not coping well (cold homes, empty fridges, recurrent falls, unmanaged incontinence/medications etc.) but previously have not had a service they could refer to address these issues. When a frail older person comes to ED, they are more likely than others to be admitted to hospital, and unnecessary hospital admission is associated with the risk of falls, malnutrition, hospital acquired infection, deconditioning and loss of function and independence. Also, older people who are transported to ED but do not need to be admitted spend a number of hours in ED before needing to arrange their own transport home at their own cost. It is anticipated that negating the need for frail people to be transported to ED by providing ORBIT outreach will lead to better outcomes for patients. We also accept referrals for those displaying evidence they are not coping at home, as earlier intervention for these people may decrease the risk of that person reaching crisis point.

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Patient Stories:

- St John were called out to a 96 year old lady who had fallen in her home, she was determined to remain at home. St John paramedics deemed she had no medical reason, or injury to present to hospital, but they had ongoing concerns regarding her safety, so St John phoned ORBIT whilst at her home with these concerns. ORBIT advised they could visit the lady within an hour therefore St John staff were happy to leave her at home.

Orbit team assessed this lady at home, equipment was issued (bed side commode, walking frame) and her mobility was reviewed. She had a good package of care in place already. She was happy with this intervention and remained safely in her home. This lady has not presented to hospital since our visit.

- 87 year old man, fell at home when getting up in the night to go to the toilet. He has had many recent falls. St John Ambulance referred to ORBIT who completed a home visit the same day. On assessment, hazards in the home that may be contributing to his falls were identified; such as lack of space to get the walking frame beside the bed, or into the bathroom safely, as there was a lot of furniture in the home. With his agreement, the bedroom and bathroom furniture was moved to enable him to mobilise freely and safely between these areas with his walking frame. Referrals to engAGE community MDT and orthotics were also made. This man has not since presented to hospital.

Benefits and results

The ORBIT St John Frailty Pathway commenced as a trial on 7th June 2016. In the nine week period from 7th June - 5th August ORBIT received 33 referrals from St John (averaging approximately four per week). Initial referrals were largely appropriate, and both St John staff and the ORBIT team were pleased with the outcomes. Initial indications were that the workload generated, though considerable, was sustainable. During the initial phase weekly reports were provided to St John on the outcomes of referrals with a view to encouraging ongoing referrals. After this initial trial period this referral pathway became business as usual.

Since then (7th June to 18th July) Orbit received 70 St John referrals.

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	The youngest person referred was 44 years old and the oldest was 98 years old. The average age of people that received input was 80.97. The vast majority of referrals were to do with St John being called out the person's home due to falls. St John referred to ORBIT for falls prevention, equipment provision, and for packages of care. The majority of people received a home visit on the day of referral and others, within 48 hours. A number of referrals were sent to community engAGE, Community Occupational Therapy, and Physiotherapy and for increased packages of care. While numbers of referrals are low, experience for those referred is considerably improved by receiving assessment in their homes rather than being transported to ED. Reports are that satisfaction with this service amongst St John Ambulance staff is high: "This pathway is a unique opportunity for St John Ambulance Staff to have the ability to obtain support services directly from the Hawke's Bay DHB, removing the need for the patient to be referred from their GP. Through this relationship we can provide our patients with a level of support and follow up care that is unprecedented both in Hawke's Bay and provincial New Zealand. The predicted result is a reduction in hospital admissions and an ability for patients to remain in their own home longer without the need for residential care". Acting Territory Manager St John Heretaunga
Future plans	Hawke's Bay DHB has recently appointed a Falls Coordinator to coordinate falls prevention input for older people at high risk of falls. As the majority of referrals from St John to ORBIT relate to falls, we plan to link closely with this falls coordinator so that when we receive a referral for an older person who is experiencing falls, we can ensure the most appropriate falls prevention strategy is put in place. St John have recently developed a"111 Clinical Hub". This is a service to where a number of low acuity calls to St John, that are deemed not to require ambulance response, will be referred and a team of clinicians will provide advice.

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	Talks are ongoing with St John and staff at the Clinical Hub to extend the ORBIT St John Frailty Pathway as a referral option for people who are referred to the Clinical Hub. This provides the opportunity for ORBIT to provide a response to older people who have called St John for assistance but may in fact benefit from a rapid response home assessment rather than an ambulance response.

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