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Conference Abstract

Integrated care in the Caredoc Community Intervention Team

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Abstract

Purpose: To implement an innovative integrated community intervention team (CIT) to empower patients, support general practitioners, community services and the acute hospital by facilitating hospital admission avoidance and early hospital discharge.

Objectives
- To support patients by providing treatment in the community
- To prevent unnecessary admissions and readmissions to hospital
- To facilitate early discharge of patients from hospital
- To educate, motivate and empower patients and their carers
- To integrate patient notes across the hospital, community and general practitioners

The innovation was developed to provide a high quality service that supports patients, primary care and hospital services by utilising and optimising existing resources. The objective of the CIT is to provide acute nursing services to patients in their own home or care facility or appropriate treatment centre. Patients spend less time in hospital and in some cases patients avoid hospital admission completely.

Background: The Caredoc CIT developed and enhanced the relationships between the hospital, community and primary care settings to support patients and healthcare services delivery so that safe and effective care is delivered to patients in the appropriate setting.

The Caredoc CIT is an excellent example of enhanced cooperation built on the synergy developed over years. It provides a seamless interface between primary & community based healthcare providers and the hospital multidisciplinary team thus bridging the gap for patients. This new model of healthcare is reactive to patients needs and provides the nursing care patients require in their home rather than moving a patient to the hospital or prolonged stays in hospital.

The clinical records of the CIT patients are managed via an electronic record system and nurses enter their patient consultation notes on devices at the point of care.

The CIT provides a range of acute nursing care interventions to patients. These interventions include: completion of intravenous (IV) therapy, PEG tube insertion / reinsertion, catheterisation (male, female and supra-pubic), medication reconciliation, discharge support to patients with chronic diseases and post-operative patients.

Conclusions: The main objectives are met on a continual basis with extra benefits of:
- Less exposed to hospital acquired infections
- Regain independence quicker and experience a faster recovery
Patient Satisfaction Survey: 100% of respondents deemed the service excellent or very good.

CIT covering a population of 121,000 for 1 year;
- Interventions: 3,883
- Hospital bed days saved: 2,304
- Ambulances avoided: 215

Internationally lessons can be learned from the cooperation and collaboration of the teams involved, mainly, the need for focused meetings concentrating on the CIT service only, to ensure relevant personnel contribute meaningfully and engage with all those involved.

Keywords

integrated care projects, community-based integrated care, avoidable admissions, care integration, health and social care integration, care co-ordination, collaboration, delivery of health care, health, integrated care models

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Powerpoint presentation:

http://www.integratedcarefoundation.org/content/integrated-care-practice-case-management

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