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CONFERENCE ABSTRACT

Caredoc Community Intervention Teams - Multidisciplinary Approaches to Delivering Care in the Community

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Introduction: Caredoc Community Intervention Team (CIT) has been operating for 10 years and during that time has expanded its service to cover 6 regions in the South East of Ireland. A central objective of the service is delivering holistic and integrated care in the community that meets the needs of patients and their families. In 2021 the service model was enhanced to include Occupational Therapy and Physiotherapy professionals to the team to work collaboratively with Nursing colleagues, thereby reducing multiple hospital appointments and supporting early discharge from acute hospitals and community rehabilitation, particularly for elderly and clinically vulnerable patients, by shifting delivery of multidisciplinary care to patient's homes.

Aims, Objectives, Theory Or Methods: The CIT service is deployed 7 days a week, 365 days a year and bridges the gap between acute care and the patients who require it by providing access to timely, flexible, ongoing and personalised treatment in clients' own homes for the duration of their illness, thus avoiding hospital admissions and enabling early supported discharge. For patients and their families this offers enormous relief and support, particularly while living with the Covid-19 pandemic, as the service provides a wide range of home-based assistance, from medication management to advice around necessary equipment and changes to the home environment to improve rehabilitation.

Highlights Or Results Or Key Findings: Strong linkages with hospital and other community-based teams have been formed to ensure continuity of care for patients and optimisation of key healthcare resources – joint home visits with other CIT professionals involved in individual patients' care have been coordinated to streamline and improve access to appropriate care. These links have also allowed for the co-design of structured referral pathways from local hospital clinics to the service, enabling the CIT Team to offer care to patients requiring regular monitoring at home, thereby reducing unnecessary hospital visits and supporting earlier supported discharge from acute hospitals. The impact of this interdisciplinary, collaborative approach has been hugely positive on patients' health and wellbeing along with the additional benefit of decreasing pressure on hospital-based services.

Conclusions: The diversity of disciplines within the CIT service ensures that all aspects of a patient's recovery is managed, and the team's on-going and effective communication strives to optimise individual treatment plans to achieve stabilisations, ensure patient safety, avoid hospital admission and enable supported earlier discharge. The team also provides acute nursing

services to patients discharged to residential care, with the overall effect of increasing capacity and bed availability in local hospitals.

Implications For Applicability/Transferability, Sustainability And Limitations: In just under a year of service the multidisciplinary CIT team carried out almost 10,000 visits to patient homes – each client referred to the service has an average of 3 encounters with the team, ensuring that multi-faceted reablement is achieved for patients while remaining in their own homes.