Comprehensive Aged Residents Emergency and Partners in Assessment Care and Treatment (CARE-PACT)

Initiative Type

Model of Care

Service Improvement

Status

Sustained

Added

06 October 2017

Last updated

12 August 2024

URL

https://clinicalexcellence.qld.gov.au/improvement-exchange/care-pact

Summary

The Comprehensive Aged Residents Emergency partners in Assessment Care and Treatment

Program (CARE-PACT) is a unique demand management program in Metro South Health that focuses on streamlining and educating the care pathway for the frail elderly residents of aged care. This comprehensive bespoke service has grown significantly in response to the COVID pandemic and fluctuating demands in the community. facilities. CAREPACT delivers a multifaceted program that works in partnership with Residential Aged Care Facilities (RACFs), General Practitioners (GPs) and Non-Government Organisations (NGOs) in providing a centralised contact for clinical support, resources, and education, with a focus on streaming and educating the care pathway for the frail elderly RACF residents. It also provides a central contact for acutely unwell RACF residents to allow specialist review or consultation. CAREPACT strives to ensure that the RACF resident can receive the most suitable care for their needs in a timely manner and in the most appropriate environment. There are seven main components to the CARE-PACT model of care.

1. Emergency support line – A dedicated, single point of contact to discuss and refer acutely unwell RACF residents to specialist care.
2. Mobile emergency team (MET) – the emergency team provides emergency department-equivalent care for residents when their health deteriorates.
3. Nurse navigator – Our nurse navigator streamlines the care pathway for frail residents to reduce unnecessary hospital stays and improve resident outcomes.
4. Inreach clinical nursing team - the in-reach teams coordinate and plan early discharges for residents in emergency departments or when they’re admitted to hospital. They include specially trained clinical nurses who are based at 4 hospitals in Metro South Health.
5. Hospital acute care substitution – We provide hospital standard acute care for residents in aged facilities who meet Queensland Health’s Hospital in the Home guidelines criteria.
6. Clinical education and support for RACF staff - We worked with GPs, RACFs and inpatient specialist staff to develop a best practice management manual for acute health concerns (RaSS Clinical Handbook). The handbook will help you decide when to refer your patient to CAREPACT or whether to replace their current services. We also GPs arrange emergency care for their patients or decide when they might need other services and care.
7. GP and paramedic direct referral line **-** We have a direct line for GPs and paramedics to refer patients to CAREPACT or talk to an emergency doctor or geriatrician instead of transferring a patient to hospital.

Key dates

Mar 2014

Jun 2017

Implementation sites

Residential Aged Care Facilities within the MSHHS catchment

Partnerships

Healthcare Improvement Unit, General Practitioners, Residential Aged Care Facilities, Queensland Ambulance Service

Key Contacts

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Aim

To improve quality of care and reduce emergency department presentations and hospital admissions for residential aged care facility residents within a framework of patient safety and choice.

Benefits

- reduce ED presentations
- reduce hospital admissions
- reduction in iatrogenic complications
- reduce LOS of ED and inpatient admissions
- increased patient and carer satisfaction

Background

The increasing percentage of older people, and those requiring residential aged care, is placing unprecedented pressure on the Hospital and Health Service. Primary care funding has not increased appreciably for over 20 years and our most at risk older people are struggling more than ever to have consistent primary care support. This is even more evident in the unplanned care of the older person.Given reported rates of presentation of RACF patients of 0.1 to 1.5 ED transfers per RACF resident bed per year, with admission rates of 40 to 60 per cent, the increasing number of RACF residents have resulted in demand pressures on both ED and inpatient beds. Patients and their families consistently express a desire to receive acute treatment in their home environments; however, existing acute care substitution models fail to leverage the unique, accredited professional environment of RACFs. In addition, there is a failure to address the complex array of factors that influence the transfer of RACF patients to hospital, including RACF staff skill mix and resources, perceived risk and patient functional and cognitive impairment.A restricted pilot of the CARE-PACT model demonstrated a 31.17 per cent absolute reduction in ED presentations of RACF patients aged 65+ years; 31.15 per cent absolute reduction in acute admissions via ED; and 26 per cent or 1.7 days reduction in inpatient length of stay of RACF patients.MSHHS applied to and received funding from the Health Innovation Fund which was created to support innovative ideas which support service delivery and patient care with the potential for statewide application.

Solutions Implemented

CARE-PACT has partnered with GPs, RACF and inpatient specialist staffs to develop a manual to guide referrals and care pathways for common avoidable presentations to the ED. Telephone triage has resulted in a nurse or ED consultant vising the RACF to deliver care where appropriate in consultation with a GP.

Evaluation and Results

Using the ROGS Performance Indicator Framework as a foundation, CARE-PACT has been evaluated on effectiveness; efficiency; equity; appropriateness and acceptability; and sustainability.The CARE-PACT project has proven to be successful in meeting its objectives of improving the quality of care for people living in RACFs, through a multimodal approach of telephone triage, mobile ED assessment, ED or hospital resource team, and a focus on building capacity of RACF staff and GPs. There has been consistent engagement of key stakeholders and high levels of satisfaction reported by stakeholders throughout the duration of the pilot phase. Overwhelmingly, it was evident that strong clinical leadership and a dedicated delivery team was a critical success factor for the results this project has been able to achieve.It is estimated that 1,522 ED presentations of RACF residents were avoided over the project duration, in addition to 2,329 hospital admissions.

Lessons Learnt

There was some uncertainty from stakeholders regarding whether there were access barriers for rural and remote populations, which is likely to reflect awareness of the geographical scope of the service.

Further Reading

Residential Aged Care clinical pathways