DML Excellence Awards 2016 Report

Project No: 158 – Caredoc Community Intervention Team (CIT)

Address: Caredoc Community Intervention Team (CIT)

Location: CHO Area 6

Brief Description (up to 200 words)

The Wicklow Community Intervention Team (CIT) is a nurse led health professional team supported by GP's and a variety of other health professionals and services. CIT provides a rapid and intergrated response to patients with acute episodes of illness who require enhanced services and acute nursing care interventions for a defined/short period of time (ideally <72hrs) in the community/home as deemed appropriate. The patient must be medically stable and meet the CIT referral criteria for care in the home / community setting. The service works inpartnershp with PCTs, Gneral Practice, Community Response Beds (CRBs), community nursing services, home support services, acute hospitals and other professionals to enhance existing services and deliver patient centred care in the most appropriate setting.

The Wicklow CIT commenced on the covering a population of 120,000 and an area of over 782 square miles and four HSE ntework areas.

Main goal(s) and aims of the Project

To create an integrated model of acute nursing care in the community supporting patients between acute and primary care services by facilitating appropriate early hospital discharge and hospital avoidance for the total population. The Caredoc CIT is an integrated partnership approach between Caredoc and the Health Services Executive (HSE).

The Wicklow CIT nursing team responds rapidly to GP and hospital referrals on a 24/7 basis 365 days a year. Patients are assessed, care is planned and implemented efficiently. Care is arranged and provided to patients in their own home, residential health care unit or at a convenient local health centre.

The aims of the service are to:

- Utilise a collaborative approach to patient care delivery
- Avoid unnecessary Hospital Admission/Referral
- Improve throughput of patients in the acute hospital setting
- Facilitate early hospital discharge
- Reduce patient referrals to hospital by GPs where appropriate
- Reduce the usage of ambulance transportation
- Provide an alternative location of care at a reduced cost
- Provide safe clinical care in an appropriate community setting

- Enable persons to maintain their health, independence and wellbeing by involving the management of their health alongside health professionals by educating and empowering patients.
- Improve real-time communications underpinned by ICT
- Achieve a high patient satisfaction level

Outline of Approach – main steps taken to implement the Project

Caredoc is a not-for-profit company that holds service level agreements with the HSE to provide healthcare services throughout the Southeast, East coast, Northeast and Northwest. Caredoc provide out-of-hours services, nurse triage and remote assessment and successfully created an innovation CIT nursing team to support patients in the community. To achieve the main objective, the first step was to build a cohesive multi-disciplinary team that understood the aims and had a common goal to succeed. The Caredoc CIT team collaborate with key stakeholders including HSE Management, acute hospital consultants, geriatricians, general GP's practice and public health nursing to develop and implement a high performing service. The strategic objectives and aims were agreed and a plan was progressed to implement an integrated, efficient and safe service to benefit key stakeholder services and their patients.

Evidenced based clinical algorithms were developed by the CIT working group which included hospital consultant and the Caredoc clinical governance team, comprising of nurses and GP's. These algorithms assist hospital doctors, nurses and therapy staff in identifying patients that are suitable for early discharge from the hospital setting to the CIT service in the community. The CIT service manages patients in the community thus avoiding hospital referrals in keeping with the strategy for primary care.

The next phase was a large communication strategy that was undertaken by the CIT nurses to cascade the information about the CIT service to primary care teams, GPs, PHNs, hospital nurse, hospital managers, hospital doctors, and directors of nursing in care of the elderly facilities, allied healthcare professionals, and hospital pharmacists. Patient information leaflets were designed and published for service users.

Specific nurse education and training programs were developed and tailored to meet the requirements of the nursing team to carry care interventions in the community setting. These include respiratory care, community oncology, urinary care, medication reconciliation and compliance. Patient monitoring and education, and chronic disease support.