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

02 May 2024

URL

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

Summary

CARE-PACT is a unique demand management program that focuses on streamlining and educating

the care pathway for the frail elderly residents of aged care facilities. There are four main components to the CARE-PACT model of care.

1. Telephone triage and clinical care planning will reduce avoidable ED presentations by providing a dedicated single point of contact for referral of deteriorating RACF patients that will enable specialist emergency geriatric clinical assessment followed by appropriate linking of the patient to the most appropriate service to attend to their care needs.
2. An ED and inpatient resource and early discharge service, maximises the opportunity for early discharge to the care of GPs, RACFs or acute care substitution services by facilitating integration of these services into the collaborative discharge planning process.
3. An ED-equivalent assessment service in the RACF will reduce avoidable ED presentations by reviewing patients with acute deterioration in the RACF, at GP or QAS request, who would otherwise be sent to EDs across the district.
4. CARE-PACT will provide inpatient hospital standard acute care substitution within the RACF to those meeting criteria of QH's Hospital in the Home guidelines.

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

Dr Ellen Burkett

0063

paul.blee.hiu

Emergency Physician

Metro South Hospital and Health Service

(07) 3176 7582

Ellen.Burkett@health.qld.gov.au

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

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 state wide 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 GP. GP and RACF staff education on care pathways.

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

Metro South Patient Flow: CARE-PACT