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CONFERENCE ABSTRACT

# The Community Intervention Team as a means of Improving the transition from hospital to home for patients

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**Introduction**: Too frequently patients are discharged from hospital to their home without local support from healthcare professionals. Without this support patients are often readmitted to hospital unnecessarily.

**Short description of practice change implemented**: Networked Community intervention team (CIT) services make a unique contribution in facilitating the transition between hospital and home.

**Aim and theory of change**: The aim is to facilitate early discharge from an acute setting, providing support and education to patients and carers, thus promoting independence and ensuring patient safety. The team provides education and medication reconciliation to patients, carers and their families, and communicates with multi-disciplinary teams, thus pre-empting relapse or crisis.

**Targeted population and stakeholders**: Patients who have been in hospital for long periods of time, and their families, working with patients and their families / carers and the multi-disciplinary teams involved in the care of the patient both in the hospital and the community.

**Timeline**: This service has been delivered in the CIT area since 2011.

**Highlights:** (innovation, Impact and outcomes) The CIT works with the acute hospitals, GP's, and patients to provide support services to improve the patients' transition. Both the patient and the family are given the necessary education and tools to remain safely at home. The CIT provides feedback and identifies any complications before they escalate to crisis, informing the specialist multi-disciplinary team that is involved in the patients care and keeping communication open.

Part of the support is accurate medication reconciliation; with every transition of care this is necessary to prevent and eliminate medication discrepancies and incompatibilities that may lead to adverse events. The CIT also provides education to patients and their carers in their home following discharge.

The outcome of the intervention is supporting patient safety, improving patient ability to self-manage medication therapy independently or with family support, increasing health care

quality and perception of quality of life, and decreasing the need for acute hospital admissions.

**Comments on sustainability**: The intervention has supported patients with a variety of healthcare conditions since 2011.

**Comments on transferability**: From a public health perspective, expansion of this nurse-led intervention has potential for significant positive effect on healthcare management and outcomes across a larger population, improving quality of life and safety, and reducing hospital stays.

**Conclusions and Discussion**: (comprising key findings) Hospitals and healthcare organizations are under increasing pressure to improve transitional care, particularly at hospital discharge. The care provided by the CIT upon discharge is a valuable resource that frees up acute hospital beds, promotes patient independence and reduces the risk of readmission. Patients and families must be supported and educated upon discharge to gain accurate knowledge and promote patient independence.

**Lessons learned**:

- Adequate education and support upon discharge reduces the risk of readmission
- Communication between the multi-disciplinary team is vital to successful transition
- Medication reconciliation reduces the risk of medication error
- Dedicated interactive IT support is a key component.
- Trust between the CIT and partners is crucial.

**Keywords:** community intervention teams; transitional care