Leading Change, Adding Value:
Rapid Response Community Service:
An Alternative to Hospital Stay for Admission Diverted Geriatric Patients

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Introduction

- **Geriatric patients** – when experience acute symptoms, seeking behavior to attend the Accident and Emergency Departments (AED)
- **About 38% of geriatric patients** (urgent/semi-urgent) – eventually admitted to medical ward through the ED.
- **Rapid Response Community Team (RRCT)** – introduced to supported Cat 3/4 M&T admission diverted geriatric patients during the winter surge period

Objective

- To establish an alternative clinical care journey to frail geriatric patients by provision of **3R community service** through “Hospital at Home” model (Rapid discharge planning, Rapid discharge support and Rapid intervention)
- To relieve M&T high bed occupancy during winter surge period
- To reduce unplanned readmission

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Methodology

**Rapid Response Community Team**

Support Cat 3 & 4 Admission Diverted Geriatric Patients
Post Discharge Care Journey

- **Target patient**
  - Cat 3/4 geriatric patients in AED Corridor with prescribed admit M&T

- **RRCT liaison nurse**
  - Assess patient’s clinical condition, frailty level, discharge needs then determine for rapid response support

- **RRCT nurses**
  - Close Symptoms Monitoring
  - For AF, Syncope, Dizziness, COPD exacerbation, Heart Failure etc.

- **Empower early warning symptoms of relapse self-management & Alerting the early symptoms & what to do**

- **Medical support from GFD Lead Geriatrician for clinical issue via phone and Fast Track Clinic support**

**Diversion Pathway of Geriatric Front Door Team in AED**

- **Workflow of Geriatric Screening at AED Front Door during Winter Surge**

  - 8:30am: Geriatric nurse selects appropriate cases for screening by Geriatrician
  - AM & PM: Geriatrician assessment and management and decide for diversion
  - Patient clinical condition and care need

  - **Admit M&T**
  - **Other Dept.**

**AED FRONT DOOR**

**Rapid Discharge**

**Hospital At Home Monitoring**

**Rapid Discharge Support & Rapid Intervention**

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Outcome

• Total number of patient admission diverted geriatric patients refer to RRCT: 221 [55 (14-15), 70 (15-16) and 96 (16-17)]
• The unplanned readmission rate: 14.6%, 11.8% and 6.9% in 2014-15, 2015-16 and 2016-2017 respectively.
• The relative reduction in unplanned readmission rate in 2016-17 vs 2015-16: 41.5%.
• Acute hospital LOS saved: 950 days

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Conclusion

**RRCT is**
- a new community model to support M&T admission diverted geriatric patients
- effective to provide safe discharge support with good outcome in admission avoidance;
- improves patient flow along the emergency and community care pathway
- improves patient and relative’s satisfaction & experience during RRCT support journey

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Acknowledge

Thank You