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Community in-reach and care transition study

Submission date
24/04/2013

Recruitment status
No longer recruiting

Registration date
25/04/2013

Overall study status
Completed

Last Edited
07/03/2016

Condition category
Other

[X] Prospectively registered
[X] Protocol
[_] Statistical analysis plan
[X] Results
[_] Individual participant data

Plain English summary of protocol

Background and study aims
The care of older people in hospital is more complex when compared to care of younger patients. For instance, their hospital stay is often much longer, the risk of complications in hospital is greater, and they are more likely to be admitted back to hospital within 28 days. In hospital, older people are given rehabilitation to help them to get better, exercises to make them stronger and information to help them cope at home once discharged. Currently this is provided by a team of therapists employed by the hospital, and is called the hospital-based rehabilitation service (THB-rehab service). When the patient is discharged from hospital, the hospital team hands this care over to a team in the community, where necessary. This study plans to evaluate a new rehabilitation service. This will be provided by a similar team of therapists, from the community but working in the hospital. When the patient is discharged home, a member of the team will visit the patient at home to ensure the discharge has gone smoothly. This service is called the Community In-Reach Rehabilitation and Care Transition (CIRACT) service. The aim of the study is to measure how effective and how expensive the CIRACT service is as compared to the THB-rehab service.

Who can participate?
Men and women aged 70 and over who have been admitted to hospital on the general medical elderly care ward as an unplanned medical admission. They have been admitted to hospital from their own home or residential care home and have their GP registered within the Nottingham City Primary Care Trust catchment area.

What does the study involve?
Once consent has been obtained and some information about the participant, their health and quality of life has been recorded, the participant will be randomly allocated to receive either the usual hospital-based rehabilitation service (THB-rehab) or the CIRACT service. The THB-rehab therapists will undertake an assessment of the participant's ability to perform certain tasks. Following this assessment, they will provide regular rehabilitation to make the participant better. When they are ready to go home, they will be referred on to the appropriate community-based services for provision of equipment at home, personal care and ongoing rehabilitation where appropriate. Once discharged from hospital, the participant will have no contact with the ward therapy staff. The CIRACT team will undertake an assessment of the participant's ability to perform certain tasks. Following this assessment, the therapist will provide regular rehabilitation to make the participant better and may even include a visit to their home before

discharge. Following discharge from hospital, the CIRACT team will visit the participant at home within 48 hours. During this visit, the level of rehabilitation required at home will be assessed and the CIRACT team will be able to undertake further follow-up visits as deemed necessary. At day 91 all participants are visited at home to ask about how they are getting on. For a small number of participants, we would like to hear in more detail about their experience of the rehabilitation service. Their opinion will be recorded in a private interview. Observations of the participant receiving the rehabilitation will also be conducted with consenting participants.

What are the possible benefits and risks of participating?
Not provided at time of registration

Where is the study run from?
Nottingham Clinical Trials Unit (UK)

When is the study starting and how long is it expected to run for?
June 2013 to November 2014

Who is funding the study?
NIHR Health Services and Delivery Research Programmes (UK)

Who is the main contact?
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Contact information

Type(s)
Scientific

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Additional identifiers

EudraCT/CTIS number

IRAS number

ClinicalTrials.gov number

Secondary identifying numbers
13931; 11HC014

Study information

Scientific Title
The CIRACT (Community In-Reach And Care Transition) Clinical and Cost-effectiveness study: the CIRACT trial

Acronym
CIRACT

Study objectives
Older people represent a significant proportion of patients admitted to hospital as an emergency. Their care, compared to younger patients is much more challenging, their stay in hospital much longer, the risk of hospital acquired problems much higher, and the risk of being re-admitted within 28 days, much greater. NHS Nottingham City Clinical Commissioning Group (Nottingham City CCG) currently delivers two rehabilitation services for older people admitted to hospital. The first is the more traditional one, where patients are assessed and managed by the hospital based multidisciplinary team (THB-rehab) and then referred on to community rehabilitation services and social services for personal care. The second is a pilot community in-reach rehabilitation and care transition (CIRACT) service. This is delivered by an occupational therapist, a junior physiotherapist and an assistant practitioner. They provide more intensive hospital rehabilitation, work closely with the patient and their carers, allow a more seamless, integrated discharge back home and then follow up the patient, at home. Compared to THB-rehab, hospital length-of-stay and re-admission rates have reduced over the 4 month period.

We now plan to undertake a more formal clinical and cost-effectiveness evaluation of this service. In parallel we propose to undertake a) a Health Economic study which will inform the cost and cost effectiveness evaluation, using direct enumeration and detailed costing rather than average cost of events, which are often in health economic complex intervention studies and b) a qualitative mechanism and action study, which will inform the explanatory and theoretically evidence of how the CIRACT intervention is implemented and experienced in relation to prevailing modes of service organisation and delivery.

More details can be found at: http://public.ukcrn.org.uk/Search/StudyDetail.aspx?StudyID=13931

Ethics approval required
Old ethics approval format

Ethics approval(s)
NRES Committee West Midlands - Staffordshire, 27/02/2013, REC ref: 13/WM/0050

Study design
Pragmatic parallel randomised controlled trial including an integral qualitative action and mechanism and health economic study

Primary study design
Interventional

Secondary study design
Randomised parallel trial

Study setting(s)
Hospital

Study type(s)
Treatment

Participant information sheet
Not available in web format, please use the contact details below to request a patient information sheet

Health condition(s) or problem(s) studied
Care of the elderly

Interventions
CIRACT service
The CIRACT team will jointly conduct an assessment of the participant's ability to perform certain tasks. Following the assessment a rehabilitation plan will be formulated which will be followed daily. The plan will focus on particular activities which are important to the participant. While in hospital the participants are treated every day (7 days a week) by the CIRACT team and the time of rehabilitation they receive will be dependent on their needs.

During the participant's hospital stay the CIRACT team will liaise with the participant and their carer(s) to visit the participant's home to carry out a home assessment in order to provide recommendations for equipment; make adaptations and/or modifications if required. In more complex cases the CIRACT team will take the participant out of the hospital for a home visit allowing assessment in the participants own home environment, if required.

Following hospital discharge, the CIRACT team will visit the participant at home within 48 hours of discharge. During this visit the level of rehabilitation required at home will be assessed and the CIRACT team will be able to undertake further follow-up visits as deemed necessary. .

THB-rehab service
The THB-rehab service, is provided by the hospital occupational therapy and physiotherapy services on weekdays only. Members of these teams jointly conduct an assessment of the participant's ability to perform certain tasks. Following this assessment the team will provide recommendation for rehabilitation. Depending on this advice, the rehabilitation care starts in the hospital, for instance when physiotherapy exercises need to be learned and these are practices with the participant if time allows. Other rehabilitation care may only require some adaptation in the participant's home and for these the ward team will be asked to refer the participant to the appropriate community based services for provision of equipment at home, personal care and on-going rehabilitation where appropriate at the point of hospital discharge. Once discharged from hospital, the patient has no contact with the ward rehabilitation staff.

Intervention Type
Other

Phase
Not Applicable

Primary outcome measure
Hospital length of stay from admission to, to discharge from the general medical elderly care ward

Secondary outcome measures
1. Super spell bed days (total time in NHS care (all hospital care+ community care / intermediate care) at 28 and 91 days post discharge
2. Unplanned hospital re-admission at 28 and 91 days post discharge
3. Disability (Barthel ADL Index) at 91 days post discharge
4. Health related quality of life (EQ-5D-3L) at 91 days post discharge

Overall study start date
01/06/2013

Completion date
01/11/2014

Eligibility

Key inclusion criteria
Eligible participants are patients:
1. Men and women aged 70 years and over
2. Admitted to hospital on the general medical elderly care ward as an unplanned medical admission
3. Admitted to hospital from their own home or residential care
4. GP registered within the Nottingham City PCT catchment area
5. Admitted Sunday to Friday

Participant type(s)
Patient

Age group
Senior

Sex
Both

Target number of participants
Planned Sample Size: 240; UK Sample Size: 240

Key exclusion criteria
1. Previously bed bound
2. Receiving palliative care
3. Moribund on admission
4. Previously included in the trial on an earlier admission
5. Admitted from a nursing home

Date of first enrolment
01/06/2013

Date of final enrolment
01/11/2014

Locations

Countries of recruitment
England

United Kingdom

Study participating centre
Nottingham Clinical Trials Unit
Nottingham
United Kingdom
NG7 2UH

Sponsor information

Organisation
Nottingham University Hospitals NHS Trust (UK)

Sponsor details
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NG7 2UH

Sponsor type
Hospital/treatment centre

Website
https://www.nuh.nhs.uk/

ROR
https://ror.org/05y3qh794

Funder(s)

Funder type
Government

Funder Name
NIHR Health Services and Delivery Research (UK) Grant Codes: 11/1023/10

Results and Publications

Publication and dissemination plan
Not provided at time of registration

Intention to publish date

Individual participant data (IPD) sharing plan

IPD sharing plan summary
Not provided at time of registration

Study outputs

Output type	Details	Date created	Date added	Peer reviewed?	Patient-facing?
Protocol article	protocol	08/02/2015		Yes	No
Results article	results	01/02/2016		Yes	No
HRA research summary			28/06/2023	No	No