Case study Abstract for Palliative Care NSW Conference taking place in Sydney in October 19-21, 2026
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The Sutherland Hospital Emergency Department & Geriatric Flying Squad Pathway

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KEYWORDS

Emergency Department & Residential Aged Care Home Outreach Team Pathway

EXECUTIVE SUMMARY (100 words maximum)

A geriatrician- and nurse-led consult service in the ED at The Sutherland Hospital, delivered by the Geriatric Flying Squad, aimed to reduce unnecessary hospital use among residential aged care residents. Expanded staffing enabled a weekday pathway from June 2024, later extended to seven days during winter 2025. Integrated into ED handovers, the team supported early assessment, discharge planning, and admission decisions. ED presentations fell by 7% and admissions by 30% in the first year; winter expansion saw further reductions of 10.4% and 11.8%. The model demonstrates effective, data-driven hospital avoidance.

INTRODUCTION

YEAR CASE STUDY WAS IMPLEMENTED

2024 to Current

CASE STUDY DETAIL

The Specific Issue

Residents of Residential Aged Care Homes (RACHs) frequently present to Emergency Departments (EDs), often for conditions that could be managed in the community. A particular challenge occurs when residents experience catastrophic medical events requiring a transition to palliative care. Facilitating a timely return to the RACH, where patients can be cared for in a familiar environment by known staff and in accordance with their goals of care and Advance Care Directive (ACD), is often difficult. Consequently, many patients are admitted to hospital despite a preference to remain in their home setting.

These presentations contribute to avoidable hospital admissions, prolonged ED stays, and increased risk of hospital-associated complications for frail older adults. At The Sutherland Hospital (TSH), there was a need to improve care coordination, support ED decision-making, and reduce unnecessary transfers and admissions for this vulnerable population.

Approach

A geriatrician- and geriatric nurse-led consult service, delivered by the Geriatric Flying Squad (GFS), was embedded within the TSH ED. The model emphasised early identification, comprehensive geriatric assessment, and collaborative decision-making. It aimed to support safe discharge back to RACHs where appropriate, while ensuring residents requiring acute care were appropriately admitted. Integration into ED workflows and strong partnerships with RACH staff were central to the approach.

Summary of Activities and Implementation

Between 2023 and 2025, increased funding enabled expansion of GFS staffing and the introduction of a dedicated ED pathway operating Monday to Friday from 3 June 2024. The service was supported by targeted education sessions and ED presentations to promote clinician engagement.

GFS clinicians were incorporated into daily ED morning handover rounds, enabling early identification of RACH residents and timely geriatric review. GFS clinicians identified patients suitable for discharge and supported the development of clear management, escalation, and transition plans in collaboration with TSH ED clinicians, GFS, and RACH staff for

acute issues such as infections, exacerbations of chronic conditions including heart failure and Chronic Obstructive Pulmonary Disease (COPD), as well as palliative and end-of-life care needs. GFS provided recommendations regarding hospital admission or supported discharge back to the RACH with appropriate referrals to GFS services. Decisions balanced clinical need with the RACH's capacity to provide safe ongoing care.

To address seasonal demand, a winter strategy extended the service to seven-day coverage between June and December 2025.

Summary of Outcomes and Measurable Impacts

The pathway demonstrated significant reductions in ED presentations and hospital admissions. Between June 2024 and June 2025, under the five-day model, ED presentations from RACHs decreased by 7 percent and hospital admissions fell by 30 percent compared to the previous 12 months.

During the winter strategy period from June to December 2025, with seven-day coverage, ED presentations decreased by 10.4 percent and admissions by 11.8 percent compared to the same period in 2024.

These findings demonstrate that early geriatric input and coordinated care planning can reduce unnecessary hospital utilisation while maintaining safe, high-quality patient care.

Scalability and Ease of Adoption

This model is scalable and transferable across health services. Core components, including geriatric expertise, ED integration, and collaboration with aged care providers, are adaptable to different settings. Implementation can be staged, beginning with weekday coverage and expanding in response to demand and available resources.

Key enablers include dedicated funding, access to a skilled geriatric workforce, interdisciplinary collaboration, and strong partnerships between hospitals and aged care facilities. Integration into existing ED workflows, such as handover rounds, supports implementation without requiring major structural change.

Important Lessons Learnt and Critical Success Factors

Early identification of RACH residents and proactive geriatric involvement were critical to success. Embedding the service into routine ED processes supported clinician engagement and sustainability.

Strong communication and collaboration with RACH staff enabled safe discharge planning and continuity of care. Ongoing education and engagement of ED clinicians were essential to build trust in the model and support appropriate referrals.

Other Comments / Information

The TSH ED GFS pathway demonstrates the value of a data-driven hospital avoidance model tailored to older adults living in RACHs. It aligns with broader health system priorities to deliver care closer to home, reduce avoidable hospitalisations, and improve patient outcomes. The model highlights how targeted investment in specialised, multidisciplinary care can achieve meaningful clinical and system-level benefits.

TSH ED GFS Pathway - 1st Year of implementation-Outcomes



The Winter Strategy June -December 2025





