“Patient Flow – Everyone’s Business across an End to End Pathway of Care”

June Patient Flow Academy

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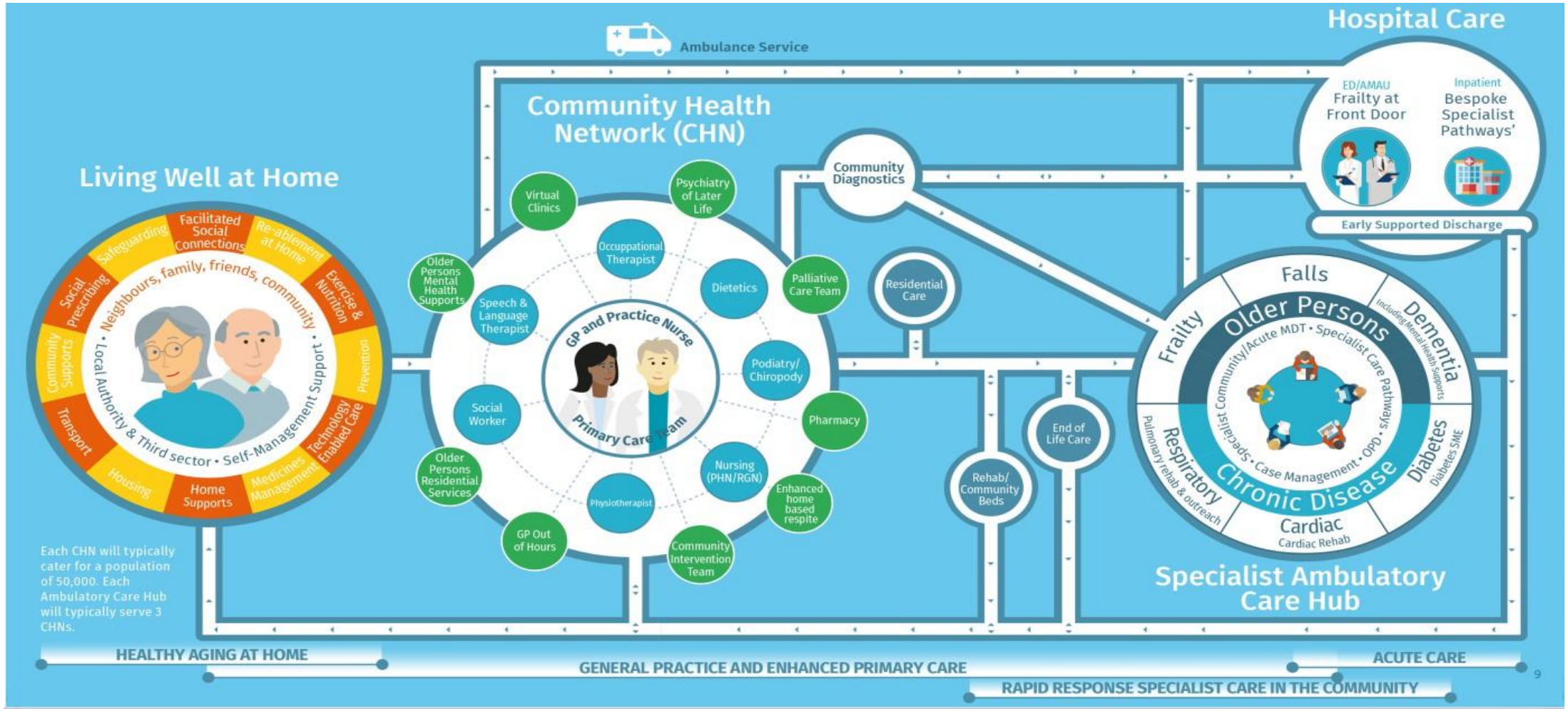
13th June 2024

Sláintecare, ECC & UEC: *Older Adults*

End to End Pathway




ED/AMAU
Frailty at Front Door
Inpatient
Bespoke Specialist Pathways'
Early Supported Discharge
Community Diagnostics
Saolta
Grúpa Ollscoile Cúram Sláinte
University Health Care Group
HSE
Falls
Older Persons
Frailty
Dementia
Chronic Disease
Diabetes
Respiratory
Cardiac
Cardiac Rehab
Facilitated Social Connections
Re-ablement at Home
Exercise & Nutrition
Prevention
Technology Enabled Care
Medicines Management
Home Supports
Housing
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Community Supports
Social Prescribing
Safeguarding
Neighbours, family, friends, community
Local Authority & Third sector • Self-Management Support


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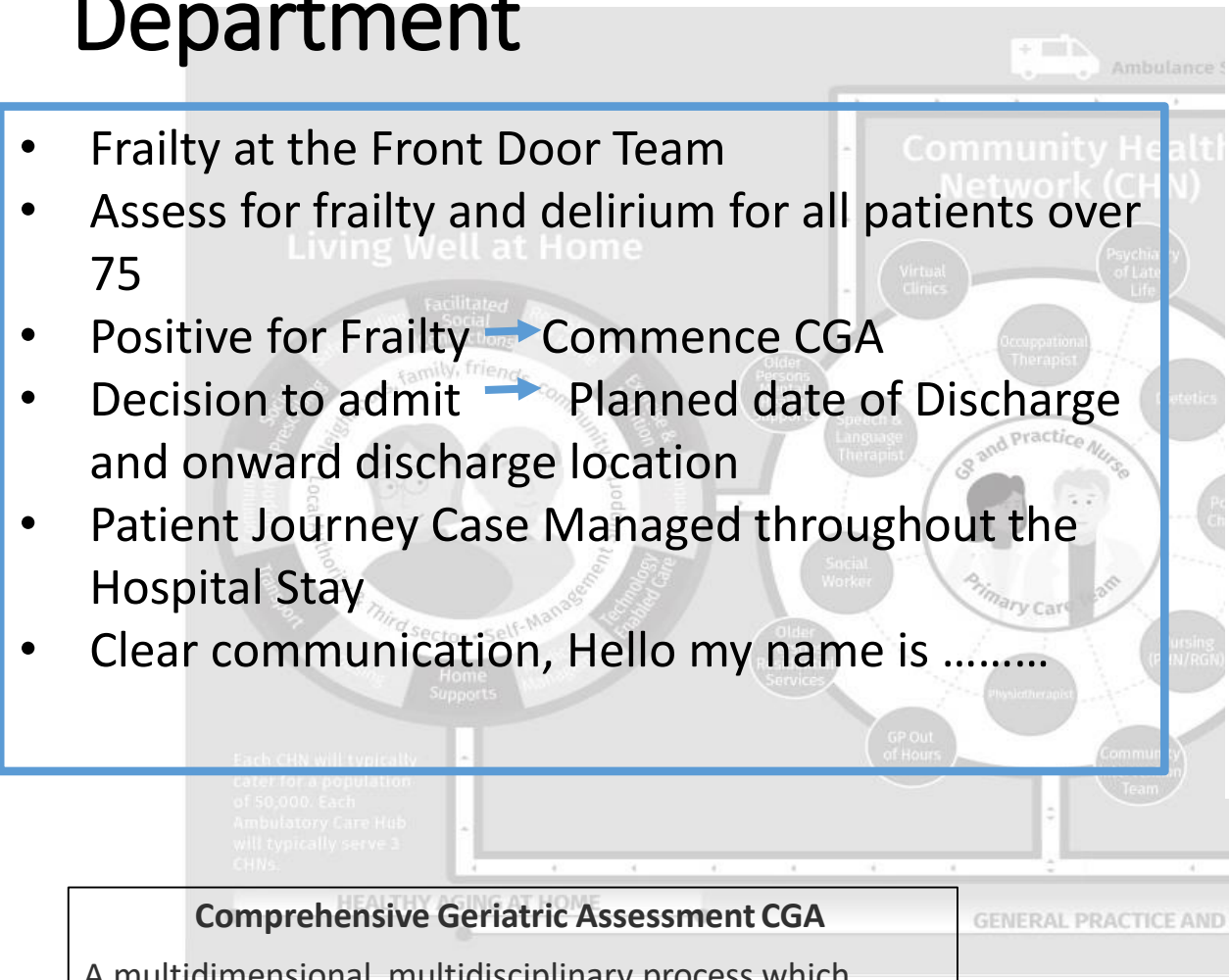
Community Healthcare Networks

1. Case finding of either pre-frail or mildly frail older adults with a view to pro-actively managing their care at primary care level.
2. Profile population of OP with complex care needs within an IHA
3. Develop priority integrated care pathways to support management and transitions of care between CHN, CST OP and Acute Hospital within an RHA
4. Implement the WHO ICOPE Framework in order that health and social care workers at the primary care level can identify older people with losses in capacities and provide appropriate care to reverse or slow these losses by following this guidance.

Case Finding Criteria:
Patients taking 5 or more medications regularly.
Patients living with one or more chronic condition.
Patients with one or more unplanned hospital admission in the previous 12 months.
Patients with a history of falls.
Patients with cognitive impairment or a diagnosis of dementia.

Hospital Care – Emergency Department

- Frailty at the Front Door Team
- Assess for frailty and delirium for all patients over 75
- Positive for Frailty → Commence CGA
- Decision to admit → Planned date of Discharge and onward discharge location
- Patient Journey Case Managed throughout the Hospital Stay
- Clear communication, Hello my name is ……



https://www.hse.ie/eng/about/who/acute-hospitals-division/national-patient-experience-survey

Comprehensive Geriatric Assessment CGA

A multidimensional, multidisciplinary process which identifies medical, functional & social needs & the development of a coordinated & integrated care plan to meet those needs

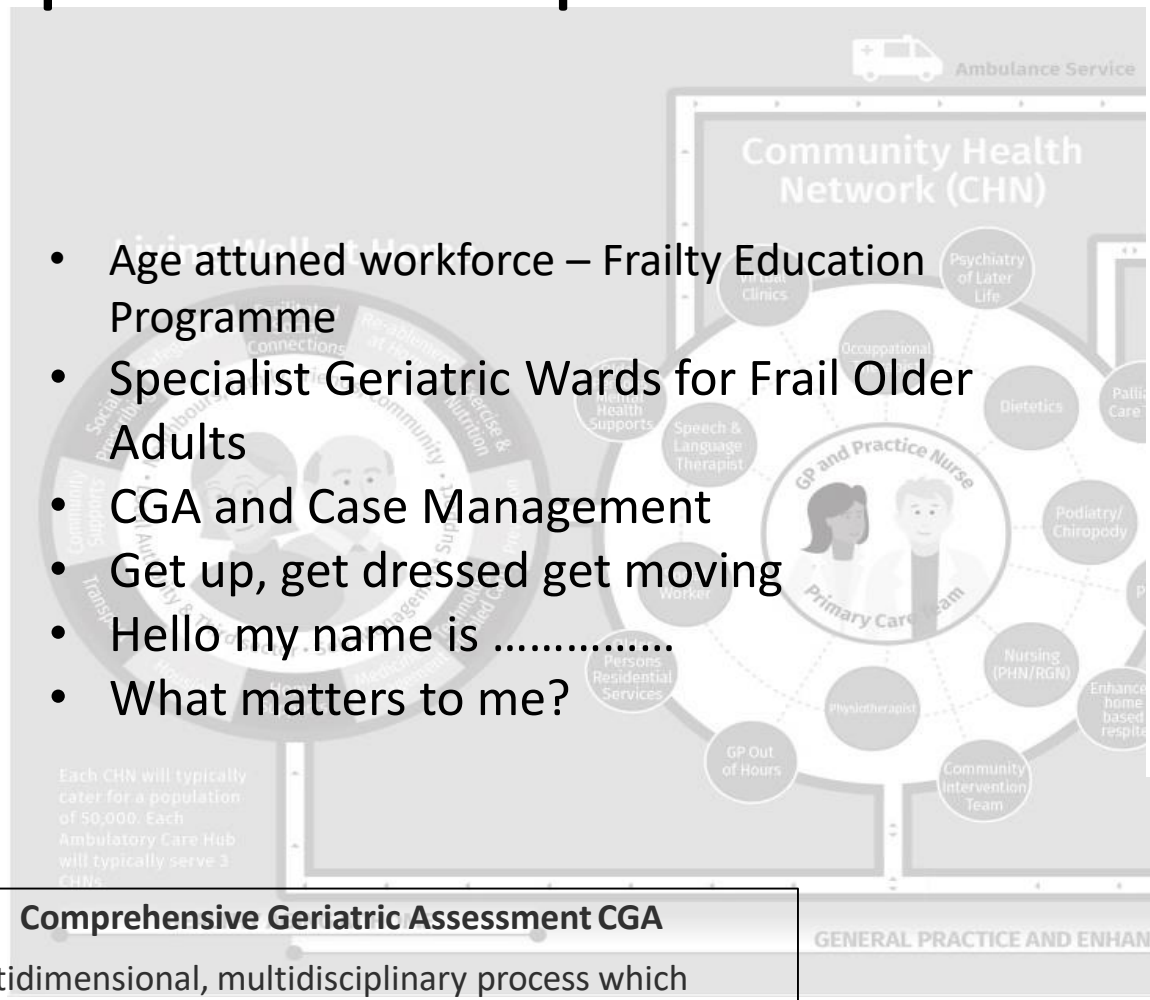
Assessment (InterRAI) & Action

Case Management (CM) for Older Adults

- Single Point of Contact
- Identification, needs assessment, care optimisation & planning
- Service & care coordination
- Early integrated discharge planning

Hospital Care – Inpatient Care

- Age attuned workforce – Frailty Education Programme
- Specialist Geriatric Wards for Frail Older Adults
- CGA and Case Management
- Get up, get dressed get moving
- Hello my name is ……
- What matters to me?



Stay on the wards

30% of patients could find someone to talk about their worries and fears

47% of patients got help from staff in time to get to the bathroom or toilet

62% of patients had enough time to discuss their care or treatment with a doctor

"Noise levels were very bad"

"Being moved was disturbing & hard to cope with"

"There was no curtain around my bed"

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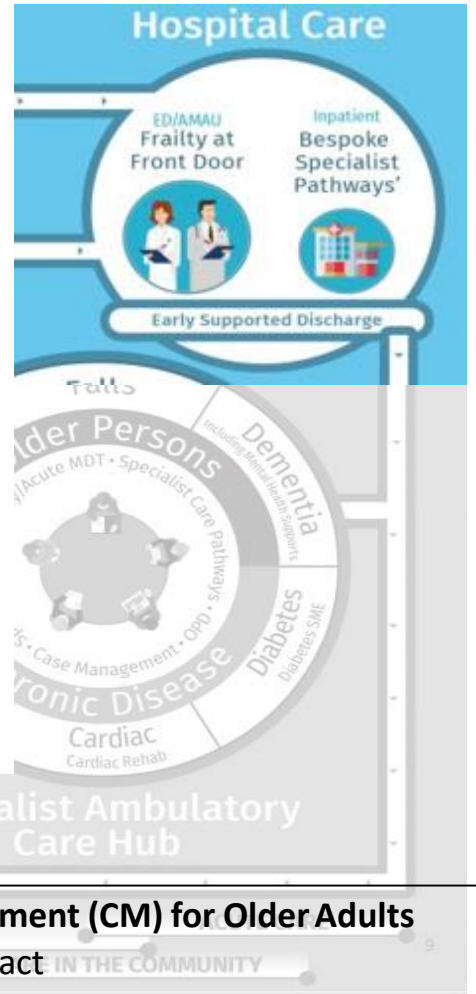

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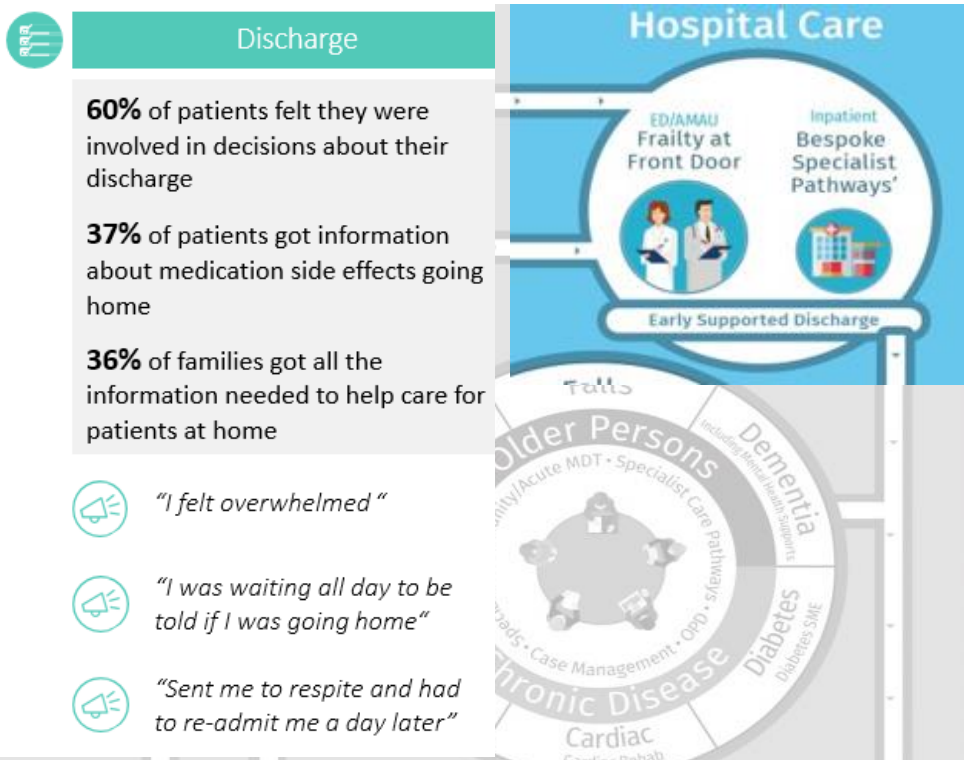
Hospital Care – Discharge

- Integrated Discharge Management
- Need for clear communication – in one study 1 in 5 re-admissions in the 90 days following discharge could be attributed to poor communication
- When acute episodic hospital care is complete and patient has continuing complex healthcare needs; a continuum of services are available for patients to be discharged to their own home or another community setting. Rehabilitation & HSS/ NHSS care planning is then undertaken in the most appropriate setting and at the right time for the person – **Home First.**
- Most of the patients waiting in our Acute Hospitals for discharge are older adults (DTOC)
- Acute Hospitals are source of 40% of all NHSS applications who, on average, wait a month in hospital



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Safe Transitions of Care

- Clear Communication with patient/family on discharge – focus on medication, follow up, what to watch out for post discharge, who to contact, what happens next.
- Build relationships with onward care location providers – again need for clear communication, comprehensive assessment of care needs.
- Full disclosure on discharge to location receiving patient – e.g. behavioural issues, family complexities, ADMA, What Matters to the Patient
- Everyone involved in patient flow needs to have a knowledge of the local health ecosystem and what services/supports are available.
- There is an urgency to change practice in public units regarding the filling of beds – need to bring people into the patient flow space and increase understanding of integrated bed management. This is difficult work and requires patience, and a spirit of co-production on what the new processes need to look like.

Thank you