Integrated Care Team for Older Persons Dublin North West

Development of a rehabilitation pathway for community dwelling older adults

An Integrated Care Initiative

Claire Campbell, Ruth Martin

National Clinical & Integrated Care Programmes
Person-centred, co-ordinated care

Introduction

Rehabilitation interventions are essential in supporting frail older adults recovery following periods of decompensation. Previously they could only access intensive inpatient rehabilitation via an inpatient stay in hospital. Primary care Physiotherapy had also raised this with the Integrated Care Team(ICT).
Within the ICT in Dublin North West(DNW) a rehabilitation pathway from the community for older adults , to two inpatient rehabilitation units was developed. Falls prevention was an overarching goal as high risk fallers are at a risk rapid loss of functional independent and prevention of same.

Objectives

1. Identify older adults in need of intensive inpatient rehabilitation
2. Design a rehabilitation pathway and SOP for community dwelling older adults
3. Optimise older adults function and facilitate them to remain at home, avoiding hospitalisation and premature nursing home admission.
4. Focus on falls prevention.

Method

An SOP was established to best identify community dwelling older adults in need of inpatient rehabilitation.

- Referrals were received from three pathways ; Holly day clinic, Community (GP and Primary Care)) and Connolly Hospital's Frailty Intervention Team(FITT)
- Each referral received a comprehensive geriatric assessment and review from both the ICT Physiotherapist and Geriatrician.
- Onward referral was then made to the consultant geriatricians in the rehabilitation units

Figure 1: Inpatient rehab referral sources

FITT	Holly Day Clinic	Community Services
3	1	4

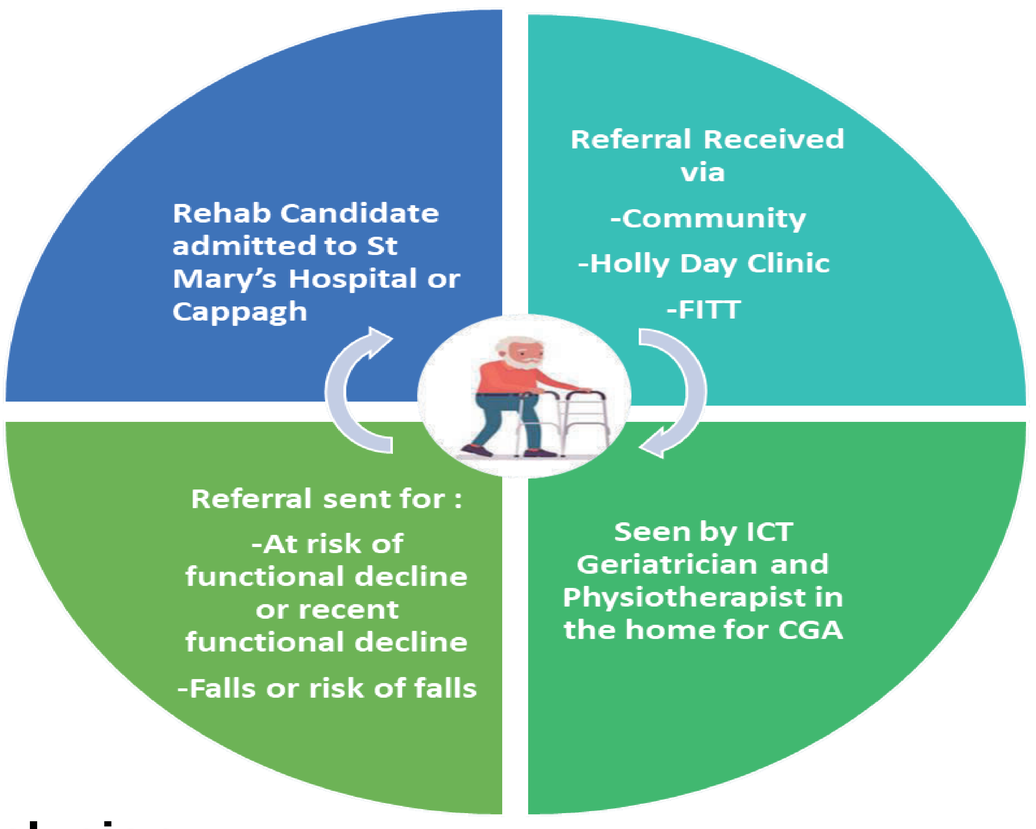
Results

From January 2023 to July 2023 a total of 7 referrals fitted admission criteria. Clinical frailty scores (CFS) ranged from being mildly frail to severely frail and all were identified as at a high risk of falls and functional decline as per the world falls guidelines.
All 7 of these received inpatient rehab in either St Mary's or Cappagh Hospital. All rehab candidates were admitted within 7 days of the referral being sent. 30 day follow up post-discharge showed all clients remained at home as per rehab goals and none had sustained a fall

Figure 2: CFS Scores of rehab candidates

Mildly Frail (5)	Moderately Frail (6)	Severely Frail (7)
1	3	3

Figure 3: Rehab referral pathway process



Conclusion

The involvement of the ICT Geriatrician and Physiotherapist in identifying and referring frail complex older adults for inpatient rehab ensured they remained at home, avoiding hospitalisation or premature admission to nursing home care. Feedback about this initiative was very positive from primary care colleagues.
Ongoing development of interagency pathways and further referrals is needed to further progress this initiative and a 90 day and fall risk outcome measure pre and post admission follow up may further demonstrate the success of this initiative.

References
1.Task Force of Global Guidelines for Falls in Older Adults.(2022). *World guidelines for falls prevention and management for older adults: a global initiative.*
https://academic.oup.com/ageing/article/51/9/afac205/6730755