Enhanced Community Care

Implementation and progression of a new clinical pathway 'Rapid access to Physiotherapy, Occupational Therapy and Dietetics (RAPOD)'

Nicola Phillips (1) Kevin Curran (2) Pamela Dalton (3) Community Primary Care, HSE Carlow / Kilkenny

Introduction

The RAPOD (Rapid access to Physiotherapy, Occupational Therapy and Dietetics) is aligned with the Sláintecare reform of championing the ethos the right care, in the right place, at the right time. It started as a joint initiative between Physiotherapy and Occupational therapy (RAPO). The aim of the project was to provide faster access to both therapies for clients in the community with significant deterioration in mobility and function and at risk of admission to hospital. As the project progressed and the Community Healthcare Network developed, the Dietetics service joined the team (RAPOD).

This project is based on the current literature advocating for joint working, early intervention and frailty prevention (Pialoux et al, 2012).

A key component of the project was to prevent unnecessary admissions to hospital due to lack of social supports or lack of access to appropriate equipment. Elderly patients represent an increasing proportion of emergency department presentations. This potentially vulnerable population are twice as likely to experience delirium and an increase in 3% risk of an adverse event per hour in an emergency department (Naouri et al, 2022) Therapists working in the project have protected slots in their diary each week for joint assessment. This preventative, proactive approach is showing great outcomes for clients in the Kilkenny area.

Aims

RAPOD is a quality improvement project. Its aims:

- to meet the needs of community dwelling patients, requiring quick access to Physio/ OT/ Dietician services, **where acute or medical care is not indicated**.
- to improve access to a multi-disciplinary response from HSCP services within Primary Care Services compared to usual care.
- To prevent admission to hospital due to functional decline.

Inclusion Criteria

Patient has to be all 3 of the below

- *Over 65*
- *Live in Network 3*
- *Have a referral to both O.T and Physio*

And also 1 of the following

- *Risk of admission or readmission to acute services and requiring allied health input*
- *Significant deterioration in mobility or transfer ability requiring urgent review*
- *2 falls or more in the last 2 weeks*

Pathway

Referral received and Screened

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Joint OT/PT assessment offered within 5 working days

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On initial joint assessment, MNA (Mini Nutritional assessment) completed- *≤11 are referred to dietetics.*

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Treatment plan agreed (continued joint visits or uni-disciplinary and/or transfer to primary care as appropriate)

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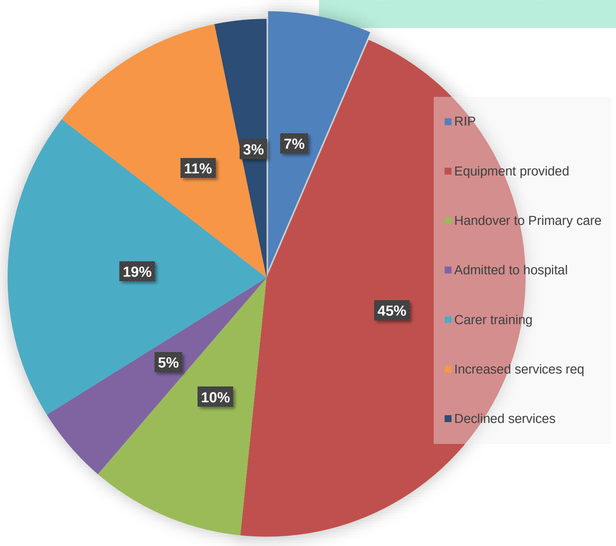
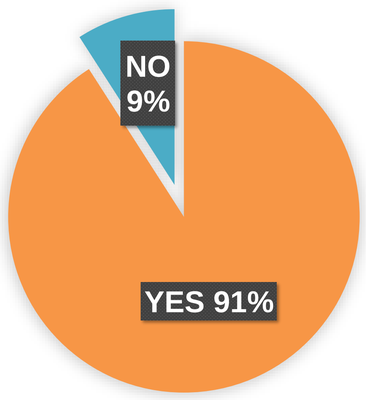
At 30 days post initial assessment patient outcome of remaining at home is checked

Interventions/ outcomes



Outcomes/ KPI'S



- 44 Patients seen in 2022 by OT/PT,
- 8 referred to Dietician following MNA screen
- Mean Age of clients was 83.76 years
- Total contacts per client ranged from 2-7
- Average wait time 3.46 working days

Patients remained at home 30 post intervention

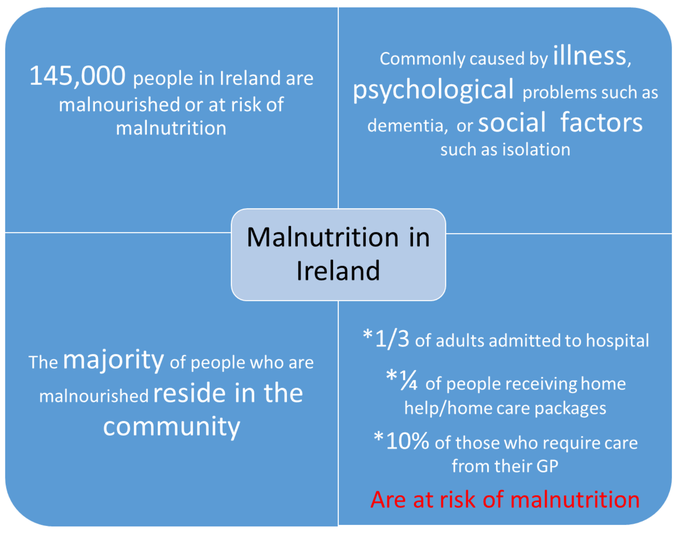
Process

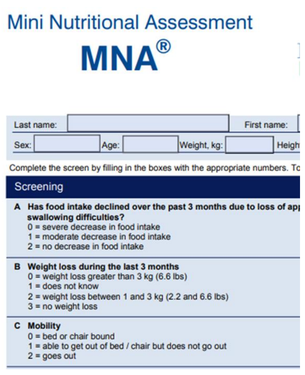
Following agreement from the involved disciplines, protected time was agreed for the clinicians to prioritise clients identified as requiring quick access to OT/PT. This was agreed as 6 hours per week and eventuated into two afternoons per week. If a client required onwards referral to dietetics, they had protected time on a Friday to complete their assessment and treatment.

The main focus of the project was joint working and timely access to a joint assessment. If a referral was deemed not to meet the criteria or the team was at capacity, the referral was treated as per individual departmental policy and waiting times.

The project required/ included:

- Working groups overseen by department managers
- Development of a standard operating procedure
- Leaflet detailing new service developed
- Role out across Primary care team with assistance from Clinical co-ordinator
- Protected equipment for quick provision.
- Assisting other networks in role out of service/ shared learning with wider team





Further plans for 2023

- Further communicate the service to public health nurses (main referrers) via formal letter to ensure fair access to service from all areas within Kilkenny city and North Kilkenny.
- Develop joint discharge summaries to reduce duplication of paperwork, streamline communication to other stakeholders and develop RAPOD as a way of working.
- Utilise electronic forms and ensure IT equipment is available, to allow onward referrals/ equipment requests to be submitted from the community.

References

Fhon, J., Rodrigues, R., Santos, J., Diniz, M. A., Santos, E., Almeida, V. C., & Giacomini, S. (2018). Factors associated with frailty in older adults: a longitudinal study. *Revista de saude publica*, *52*, 74. https://doi.org/10.11606/S1518-8787.2018052000497

Gillis, A., & MacDonald, B. (2005). Deconditioning in the hospitalized elderly. *The Canadian nurse*, *101*(6), 16–20.

Naouri, D., Pelletier-Fleury, N., Lapidus, N. *et al.* The effect of direct admission to acute geriatric units compared to admission after an emergency department visit on length of stay, postacute care transfers and ED return visits. *BMC Geriatr* **22**, 555 (2022). https://doi.org/10.1186/s12877-022-03241-x

Pialoux, Tanneguy, Jean Goyard, and Bruno Lesourd. "Screening tools for frailty in primary health care: a systematic review." *Geriatrics & gerontology international* 12.2 (2012): 189-197.

Nicola.Phillips@hse.ie Kevinm.curran@hse.ie Pamela.Dalton@hse.ie