Acute bed avoidance, direct admissions from Frailty at the Front Door to Rehabilitations Beds

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1 Background

A key priority outlined in the Programme for Government is to support the older person to live in dignity and independence in their own home. The Integrated Care Programme for the Older Person (ICPOP) Community Specialist Teams provide services for older people who have complex needs and who require Specialist Multidisciplinary intervention to help maintain their independence and for them to live well at home.

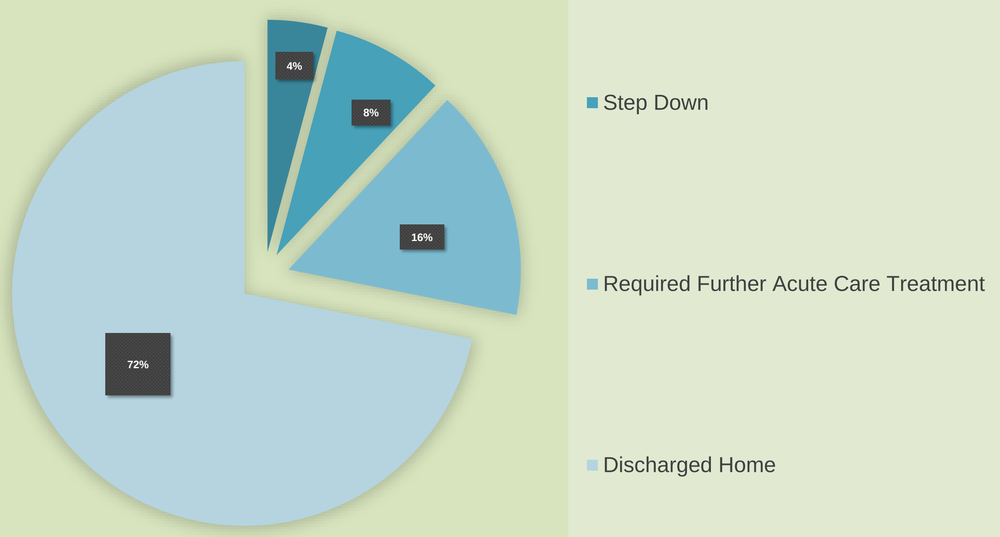
In line with the Sláinte care vision for easier access of **Right Care, Right Place and Right Time** Clontarf Hospital have developed a pathway with the ICPOP Team/ FITT Team admitting patients directly from the front door of the Acute hospital to a more appropriate environment, thus avoiding acute hospital admission or admitting directly from the community thus avoiding the Emergency Department presentation. The patients are over 65 year of age with multi comorbidities and complexities.

2 Methods

Both pathways have been developed and embedded. The ICPOP Consultant Geriatrician and the Patient Flow Teams in both Clontarf Hospital and the Mater Hospital collaborated to establish a seamless FITT to Rehab pathway which is person centred. An electronic communication group was instated to refer patients directly from the Emergency Department MMUH to Clontarf Hospital. This use of technology makes the process more efficient. The Comprehensive Geriatric Assessment Tool is utilised to refer and handover all patients. Patients being admitted directly from the ICPOP Teams in the community. The ICPOP team complete an online Clontarf Hospital referral. Clontarf Hospital Patient Flow Department contact the patient directly and arranges admission. The data is collected on Clontarf Hospital Electronic Dash Board since the introduction of the service including:

1. Source of admission either Community/Ward/FITT/ED
2. Number of Admissions
3. Age profile
4. Length of Stay
5. Discharge Destination

Patient Discharge Outcome



3 Results

Since the start of the service, mid-2022, 196 patients have been admitted via the ICPOP pathway. Over 5943 acute hospital bed days have been saved. 10.8% of admissions came directly from the community and 89.2% from the FITT Emergency Department Team. The MLOS is 22 days and ALOS is 27 bed days.

Over 70% of patients are discharged directly home, 4% of the patients were transferred to residential care, 7.6% of the patients were discharged to step down facilities and 16% required further treatment in the acute hospital. There has been significant positive feedback from patients and families.

Conclusion

4

The establishment of a direct admission pathway from the Emergency Department and the community to a rehabilitation hospital has demonstrated positive patient outcomes and overall benefits to the healthcare system. Resulting in both ED and acute bed avoidance.

References

Department of Health (2012) *Future Health: a Strategic Framework for reform of the Health Service 2012-2015*