Beaumont Hospital & National Ambulance Service:
Pathfinder Service

Paul Bernard
Clinical Specialist Occupational Therapist (Beaumont Hospital)

Lawrence Kenna
Advanced Paramedic (National Ambulance Service)

10/3/22 All-Ireland Conference on Integrated Care

This project has received funding from the Government of Ireland's Sláintecare Integration Fund (SIF 392)

Do we need to change how we work?

Beaumont 2019

- 17,708 people aged ≥ 65 years presented to ED: 47% were admitted (ALOS 14days)

Increasing ED presentations & frailty

- 22% increase in presentations of people aged ≥65 years to Beaumont ED between 2015 and 2018.
- Projected 44% increase in population aged ≥ 65 years in North Dublin by 2026
- Common trend amongst many EDs nationally and will continue to increase.

Risk to Older People

- Older people are at risk of adverse events when presenting to ED

Patients and ACP's

- Literature has highlighted that older people welcome Alternative Care Pathways (ACPs)
- Examples of ACPs in UK that are very successful
- **<u>New pathways for older people are needed</u>**

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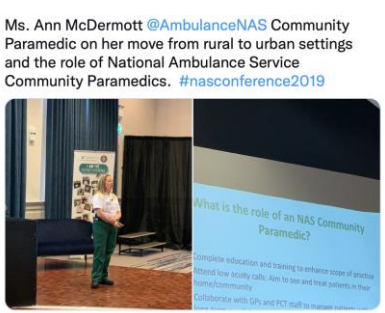
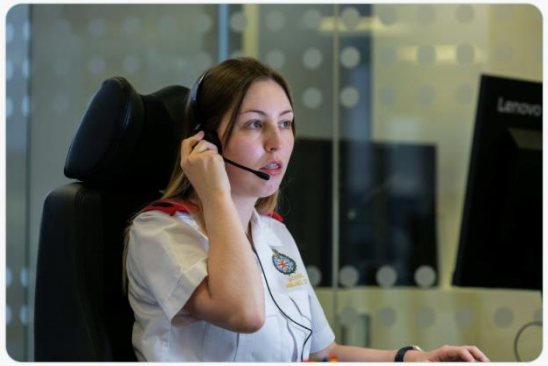
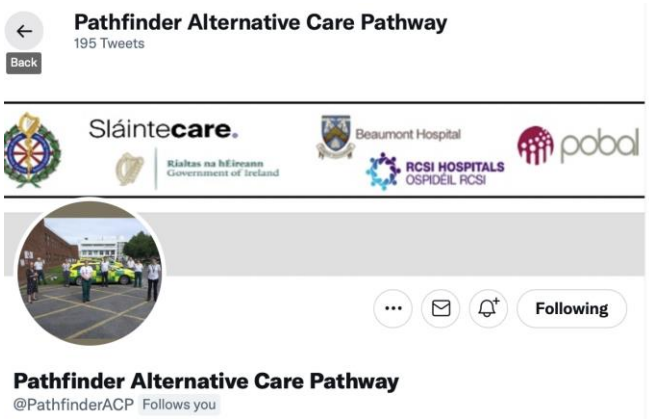
Multilayer Service Integration

Current practice for 999 calls







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Assessment

Advanced Paramedic

- Primary Survey
- Medical History (AMPLE)
- Vital signs incl. blood glucose reading
- 12 lead ECG if required
- Head to toe assessment in cases of a fall
- Urinalysis if indicated
- Medication changes

Beaumont OT/Physio

- 'Baseline' functioning + frailty screen
- Upper and lower limb power + range of motion assessment
- Transfers + functional mobility assessment
- Home environment assessment
- Cognitive screen + assessment as indicated
- Activities of daily living assessment
- Screening need for referral to HSCP colleagues

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Emergency 999/112 Call

5 Alpha/ Omega

17 Alpha/ Omega

26 Alpha/ Omega

30 Alpha/ Omega

Or

Ambulance Crew Referrals (any AMPDS code)

Pathfinder inclusion criteria:

Aged ≥ 65 years

Beaumont Hospital catchment

8am-8pm Monday-Friday

Catheter calls (including Nursing Homes)

Treat and Discharge

1. Compensatory strategies
2. Education
3. Equipment provision
4. Adaptation of home

Treat and Refer

1. Pathfinder Follow-up therapy team
2. Beaumont Hospital OPD clinics (e.g Urodynamics) .
3. Community Intervention Team (CIT)
4. Integrated Care Team (ICT)
5. Day Hospital– Geriatricians, SLT, MSW, Dietician, Pharmacy, Nursing
6. Primary Care Teams – OT, PT, GP, PHN
7. External agencies – ALONE, Siel Bleu, Alzheimers society, etc.

Convey to ED

1. Transfer of patient to Beaumont Hospital ED
2. Handover to the Frailty Intervention Therapy Team

May be appropriate for same day discharge from ED with Pathfinder follow-up

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Outcomes 2021

738 patients referred to Pathfinder Rapid Response Team

(576 seen face-to-face)

Average age= **81years**

Average Rockwood Clinical Frailty Scale= **6 (Moderately Frail**)

Over 80% of non-conveyed patients required Pathfinder **Follow-Up Therapy Team** input over subsequent days

99% of non-conveyed patients remained at home at 24hours.

89% remained at home by Day 7

67% of older people remained at home rather than the ED following 999 call

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Case Example

Background

- 999 call- general weakness (AMPDS code: 26A05)- Pathfinder tasked
- 85 y/o lady- carer dialled 999 due generalised weakness, decline in function + back rash.
- Previous medical history: dementia, orthostatic hypotension, hypertension, hypothyroidism, hiatus hernia, cholecystectomy, anaemia and right hemiarthroplasty.
- Social history: lived with son + daughter-in-law in a ground floor apartment. Homecare package of 3 calls/ day + private care. Environment well adapted.
- 'Baseline function': Mobile with rollator frame + supervision. Regular falls. Clinical Frailty Score= 8.

Pathfinder RRV Assessment

- **AP:** vital signs within normal range. Evident rash on lower back- AP queried Shingles. Minor elbow laceration (recent fall).
- **PT:** Now requiring contact-guard Ass. x 1 for mobility with frame, Ass. x 1 for all transfers. Now largely reliant on wheelchair with carers.
- Collateral from family: gradual functional + cognitive decline in recent weeks. Intermittent drowsiness + night-time agitation. Significant carer stress.

OUTCOME= NOT TRANSPORTED TO THE ED (TREAT + REFER @HOME)

1. Immediate discussion with GP- virtual consultation- antiviral medication prescribed for Shingles.
2. CIT bloods completed @ home within 48 hours.
3. 4 follow-up visits by Pathfinder (PT/ OT) over subsequent week- rehab, carer training, case-management.
4. Onward referral- Geriatrician Day hospital clinic + PCT (PHN, Social Work, Physio)

*** No re-presentation to the ED or further 999 calls in the next 30 days***

'1ST class- a great midway between hospital and home. It is what people want. Older people deteriorate psychologically in hospital. Excellent.'

British Geriatrics Society
Improving healthcare for older people
BGS
Age and Ageing

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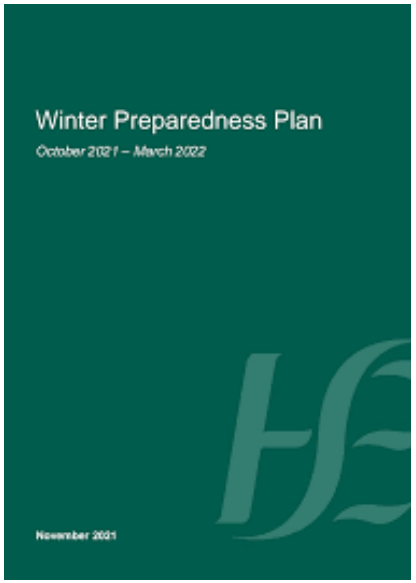
SHORT REPORT

Is Pathfinder a safe alternative to the emergency department for older patients? An observational analysis

Paul Bernard[1], Grace Corcoran[2], Lawrence Kenna[3], Claire O'Brien[1], Peter Ward[2], William Howard[3], Laura Hogan[3], Rebecca Mooney[3], Siobhan Masterson[3]

[1]Occupational Therapy Department, Beaumont Hospital, Dublin, Ireland
[2]Physiotherapy Department, Beaumont Hospital, Dublin, Ireland
[3]National Ambulance Service, Health Service Executive, Dublin, Ireland

Pathfinder Model - National Roll Out



- ✓ Focus on admission avoidance & alternative 'Pathways of Care'
- ✓ Funding allocated to scale up and expand the Pathfinder Frailty model nationally to increase ED avoidance at the most challenged Model 4 & Model 3 sites:

- ❖ *Model 4 sites: Beaumont, Tallaght, Waterford, Cork, Limerick, Galway (44 WTE)*
- ❖ *Model 3 sites: Letterkenny, Kilkenny, UHK (22 WTE)*

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Email: pathfinder@beaumont.ie

@PathfinderACP

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