ICPOP Community Rehabilitation Service

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Backround

Hip fractures are a major public health issue due to ageing populations and Ireland has one of the highest hip fracture rates in Europe[1]. The cost of acute hip fracture care was 48.5 million euros in 2022[1].

The Irish Hip Fracture Database in 2022 revealed that 84% of people presenting to acute hospitals with hip fracture were admitted from home, however only 29% were discharged directly home[2].

NICE guidelines recommend early supported discharge for patients who are medically stable and mentally fit to participate with rehabilitation and who can transfer and mobilise short distance but have not yet achieved their full potential[3]. The National Integrated Care Programme for Older Persons (NICPOP) improves the life of older people by providing access to integrated care and support that is planned around their needs and choices, supporting them to live well in their own homes[4].

This poster outlines the rehabilitation pathway established by the SJH ICPOP team to provide early supported discharge for hip fracture patients.

AIM

THE SJH ICPOP Rehabilitation pathway aims:

- To provide Early Supported Discharge from St James's Hospital.
- To provide intensive and coordinated MDT- based rehabilitation in the client's home.
- To improve the quality of life and wellbeing status of older persons by encouraging and facilitating improved socialisation opportunities and community-based skills engagement.
- To avoid presentation to ED and hospital admission by providing rehabilitation to preserve or improve functional levels essential for community-based living.

Criteria

Inclusion Criteria
• People over 65 years of age • Medically stable • All older persons regardless of GMS status • Resides within defined catchment area of CH07 which aligns to St James Hospital. • Off baseline with clear and achievable (SMART) rehabilitation goals. • Independently transferring or care arranged to safely allow same. • Independently toileting or appropriate care in situ to facilitate same. • Older persons consent and motivation to work towards goals in own home. • Older persons at risk of a decline in functional ability in the absence of rehabilitation.

Intervention

Suitable patients are identified and assessed prior to discharge from the acute ward – this may include an access home visit by ICPOP MDT.

Each patient receives a comprehensive geriatric assessment in their own home that includes setting SMART goals.

Rehabilitation commences within 72 hours of discharge from SJH and lasts for six weeks.

In line with the Chartered Society of Physiotherapy hip fracture standards (2018)4, all patients receive at least 2 hours of therapy per week until they have reached their goals. Therapy can be provided by any MDT member.

Standardised outcome measures including Functional Independence Measure (FIM) and EQ5D5L are captured for each patient.

Clients are discussed weekly at ICPOP multidisciplinary meeting.

Clients are discharged once they have reached their goals or are at their new baseline.

Patient satisfaction is measured through the use of a survey at time of discharge.

Results

30 patients were seen on the rehabilitation pathway in 2023, an increase in comparison to 2022, reflective of increased staffing on the ICPOP team.

Average Clinical Frailty Scale score was 4 and average length of stay on service was 40 days.

Average wait time to first assessment was 2 days, highlighting the responsiveness of the service.

FIM scores increased from 148 to 160 on average- a higher score is indicative of more functional independence.

Conclusion

The SJH ICPOP Rehabilitation pathway offers a high quality service, supporting early discharge from acute hospital and resulting in acute bed days saved. Improvements can be seen in patients' functioning after their participation in the programme and encouragingly, readmission rates were low post discharge from the service.

References:

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