

Specialist Geriatric Services Pathway

Stage 1
Prevention is needed wherever OP lives, incl. NH, Community/Specialist Units

Stage 2 Identify persons AT RISK (Level 1&2)

STAGE 3 Multi-factorial Interventions (Level 2 & MFI)

Older person keeping well in the community
Opportunities for prevention via primary care / national programmes
Eg: Vaccinations 'flu / pneumococcus, Falls prevention, Exercises, Formal Education / communication process [national media, local media, public]

Clinical problem arises – older person

General Practitioner (GP)/ Primary Care Team (PCT)

Emergency Department/ AMAU
Assess for referral to SGS

Primary Care solves problem
Opportunity for screening and chronic disease management

Referral to SGS for Comprehensive Geriatric Assessment

Ambulatory Day Care

Community Based

- Patient presents at GP/ PCT/ Community hospital, or is seen by outreach team
- Access to respite, rehab, Community support services

Day Hospital/ Hospital Outreach

- Patient presents at day hospital: or is seen by outreach team
- A Comprehensive Geriatric Assessment [CGA]
- Diagnostics in timely manner
- Access to respite, rehab, support services

Admit to Specialist Geriatric Ward or Other
(Acute Patient Pathway and Care Process)
Patient admitted directly to SGW / Other +/- Inpatient Rehabilitation Onsite

Discharge Plan 1 – HOME

- Home without any additional input from hospital i.e. primary care follow up
- Home with ambulatory follow up in OPD / day hospital
- Increased supports in community i.e. Equipment, assisted discharge package (home help, HCP, other)
- Links to palliative / psychiatry / others

Discharge Plan 2 – NOT HOME

Off Site Rehabilitation /Other Acute Hospital

- With ambulatory follow up in OPD / day hospital, outreach follow up, equipment
- Links to palliative / psychiatry / others

Discharge Plan 3 - Extended Care

To Longterm Residential Care or Transitional Care Unit

- Without any additional input from hospital
- With outreach to longterm residential care



Feidhmeannacht na Seirbhíse Sláinte
Health Service Executive

National Care of the Elderly Programme 2012



Schematic Integrated Care Pathway Model for National Falls & Bone health Implementation Project (AFFINITY)

Stage of Care – 1. Prevention 2. Case Finding/AT RISK 3. Interventions	Community Setting	Hospital Setting
FALLS PREVENTION	Older person keeping well in the community 65 years and older	
	Clinical problem arises <i>Eg. Fall with suspect fractured hip</i>	
	Referral to GP/out of hours GP service/PCT	Or/and Referral to Emergency Department/AMAU
CASE FINDING/AT RISK (Level 1 Screening Assessment & Level 2 <i>if necessary</i> Multi-factorial Falls Risk Assessment)	Problem resolved with opportunity seized for screening and chronic disease management in clinic/at home/LRC or transitional unit	<ul style="list-style-type: none"> • If HIP FRACTURE, urgent referral to Orthopaedics & for Medical Assessment if necessary • Referral to Specialist Geriatric Service for Comprehensive Geriatric Assessment (CGA)
INTERVENTIONS (Level 2 Multi-factorial Falls Risk Assessment <i>if not already done</i> & Level 3 Multi-factorial falls Interventions)	<p>Ambulatory Day Care that is</p> <ul style="list-style-type: none"> • Community based i.e. GP/PCT/OPD/Community hospital/outreach team for respite, rehab, community supports • Day Hospital/Hospital Outreach for timely diagnosis/CGA/access to respite, rehab, community support such as equipment, HCP, home help etc <p>Offsite Rehabilitation/other acute hospital (Model 2/3/4) with ambulatory follow up in OPD/day hospital/hospital outreach with/without links to psychiatry/palliative/others</p> <p>Long term Residential Care Unit (LRCU) With/ without additional inputs from hospital outreach</p>	Admit to Specialist Geriatric Ward or Other +/- inpt rehabilitation onsite