ICT Enablement of Older Persons Services

Health Information and Quality Authority
An tÚdarás Um Fhaisnéis agus Cáilíocht Sláinte

Caroline's story (Public Health Nurse)

Hi, I'm Caroline. I'm the public health nurse in Mark's local Primary Care Centre and and I got his referral from the step-down facility.

When Mark was taken into hospital after his fall, he had an assessment by the multi-disciplinary team, which is led by a consultant geriatrician. Mark told me that the whole team developed a care plan, which included time in a step-down facility, then discharge home with home support and physiotherapy. I got Mark's referral to the Primary Care Centre but didn't receive his care plan.

I visited Mark the day after I received the referral and did an assessment. After his fall, he needed to continue physiotherapy treatment so I arranged for the physiotherapist to visit later that week. The physiotherapist assessed and treated Mark, and arranged for the occupational therapist to see Mark the following week, to see what adjustments should be made to his home. After agreeing with Mark, I also got in touch with homecare support to discuss Mark's need.

What was Caroline's experience with Mark's health information held on paper?

"Everything is documented but sometimes it has been photocopied a few times and can be quite difficult to read, and there's so much paper, such as the care plan and the copies of the referrals. I only got his referral to the Primary Care Centre two days before he was discharged, and visited him as soon as I could.

Mark told me about the referrals for physiotherapy and the homecare package, otherwise I was still waiting for information. Mark's general practitioner (GP) had not received the discharge summary at that point either. Initially, the physiotherapist relied on Mark's memory of his exercises, as she had no information on the treatment he had received before. The physiotherapist, the occupational therapist and I all did separate assessments, so Mark also had to keep repeating the information.

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At the end of the day, Mark got the care he needed. However, if we all had access to the right information at the right time, Mark wouldn't have needed to keep repeating his information or have to undergo several different assessments. It's even harder when someone has cognitive challenges."

A digitally-enabled health service has the potential to allow Caroline a more comprehensive picture of Mark's care.

"It took me a while to get comfortable with the new systems, and there were a few teething problems with them, but nothing serious and they've made such a difference.

When Mark was admitted after his fall, the hospital team could see his high blood pressure and breathing issues, his medications, and all treatments he had. They confirmed this with Mark and his family, but it meant they had a much clearer picture to begin with. When Mark was ready for discharge, the hospital could see the places available in the step-down facility and, after he'd had treatment there, they could see the home support packages application had been received and approved in his area.

There was also time to prepare before his discharge: I could see all Mark's referrals before he came home and could get the team ready to treat him. The system showed me that the physiotherapist, the occupational therapist, and the home support service had all received his referrals and we arranged to meet as a team with Mark on the day he came home. We did one assessment, informed by relevant information stored electronically, and agreed a care plan with Mark.

This meant that we could hit the ground running: for example, the physiotherapist could see his treatment in hospital and in step-down care, while the occupational therapist had arranged for the equipment he needed to manage at home to arrive the next day. Everyone knew what was happening, especially Mark himself."