

# The Power of 'PEDAL'

Pulling it all together to achieve  
sustained discharge

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# PEDAL

- Post Emergency Department Assessment & Liaison
- Dedicated registered district nurse & social worker
- Monday to Friday: 8:00 am – 4:30 pm
- Located in the Hospital Emergency Department
- Implemented under the umbrella of MidCentral Health's Assessment Treatment & Rehab Services

# Goal of Assessment, Treatment & Rehabilitation Services

*“to meet peoples disability and/or age-related needs  
in order to maximise their functional ability and  
enable them to live as independently as possible”*

(Ministry of Health Service Specifications for A T & R Services)



# Why was PEDAL established in ED?

- Between July 2002 & June 2006, MCH ED presentations increased by 20%
- 31% were people aged 65+, the main age range being 75-84 years.
- 49% of those who presented to ED and went on to be admitted were 65+.
- 13.5% of our region's population is older than 65; and utilise 67% of MidCentral acute hospital beds.

# Between July 2002 & June 2006

- Re-presentations within 30 days increased by 42%.
- 30% of representations within 30 days were for people over 65 (the main age range was 75-84 years).
- 52% of those who represented within 30 days were admitted.

# What does PEDAL do?

Collaborates with the ED & MDT to identify patients who are at risk of:

- an unnecessary hospital admission
- being unable to sustain their recovery at home (short & long term)

# Promote sustainable & safe discharge by:

- Highlighting patients requiring additional assessment and/or management.
- Providing advice re options & planning for community care.
- Advocating for admission if necessary.
- Arranging & co-ordinating support packages.
- Informing the patient's wider PHC team of the plan
- Remaining available for 24 – 48 post discharge with a home visit as required.

# Key PEDAL success factors

## 1. Assessment

- Looks beyond the immediate reason for presentation
- Gathers information from a wider range of sources
- Joint PEDAL Nurse and Social Worker assessment
- Holistic approach

# Key PEDAL success factors

## 2. Patient & family centred approach that fosters their participation and commitment

- Participation
- Commitment to implementation

# Key PEDAL success factors

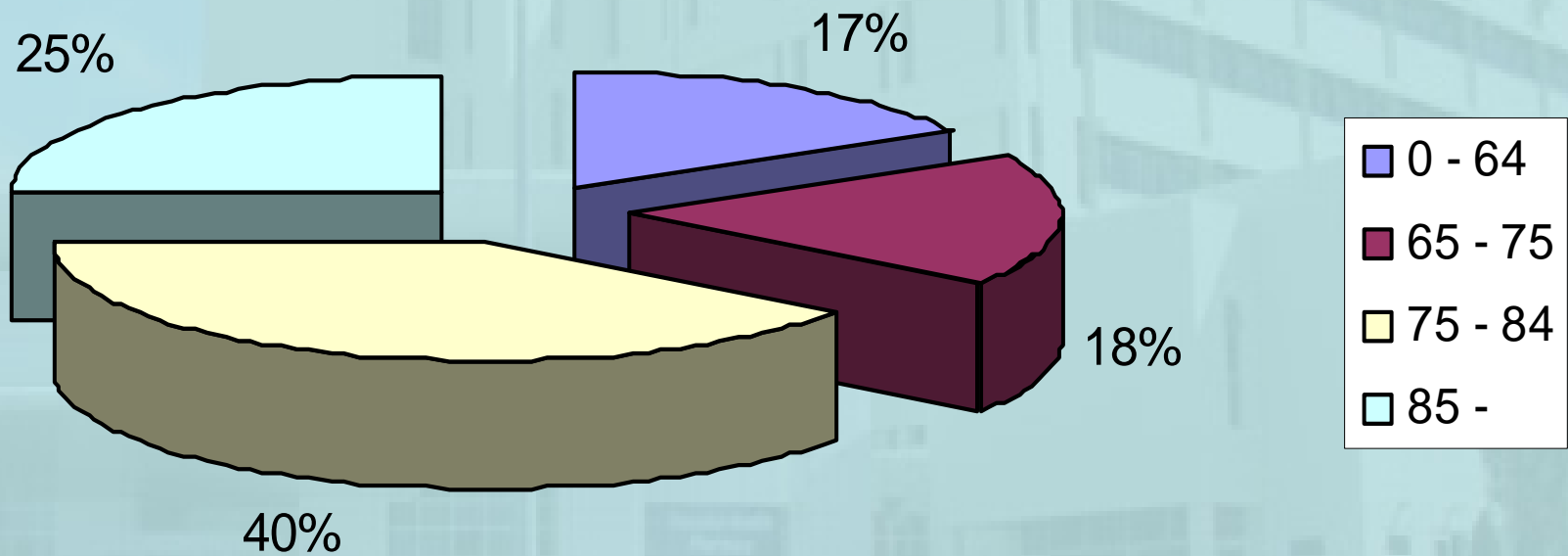
## 3. Individualised & community focussed support package geared to:

- Managing the patient's short term needs

**AND**

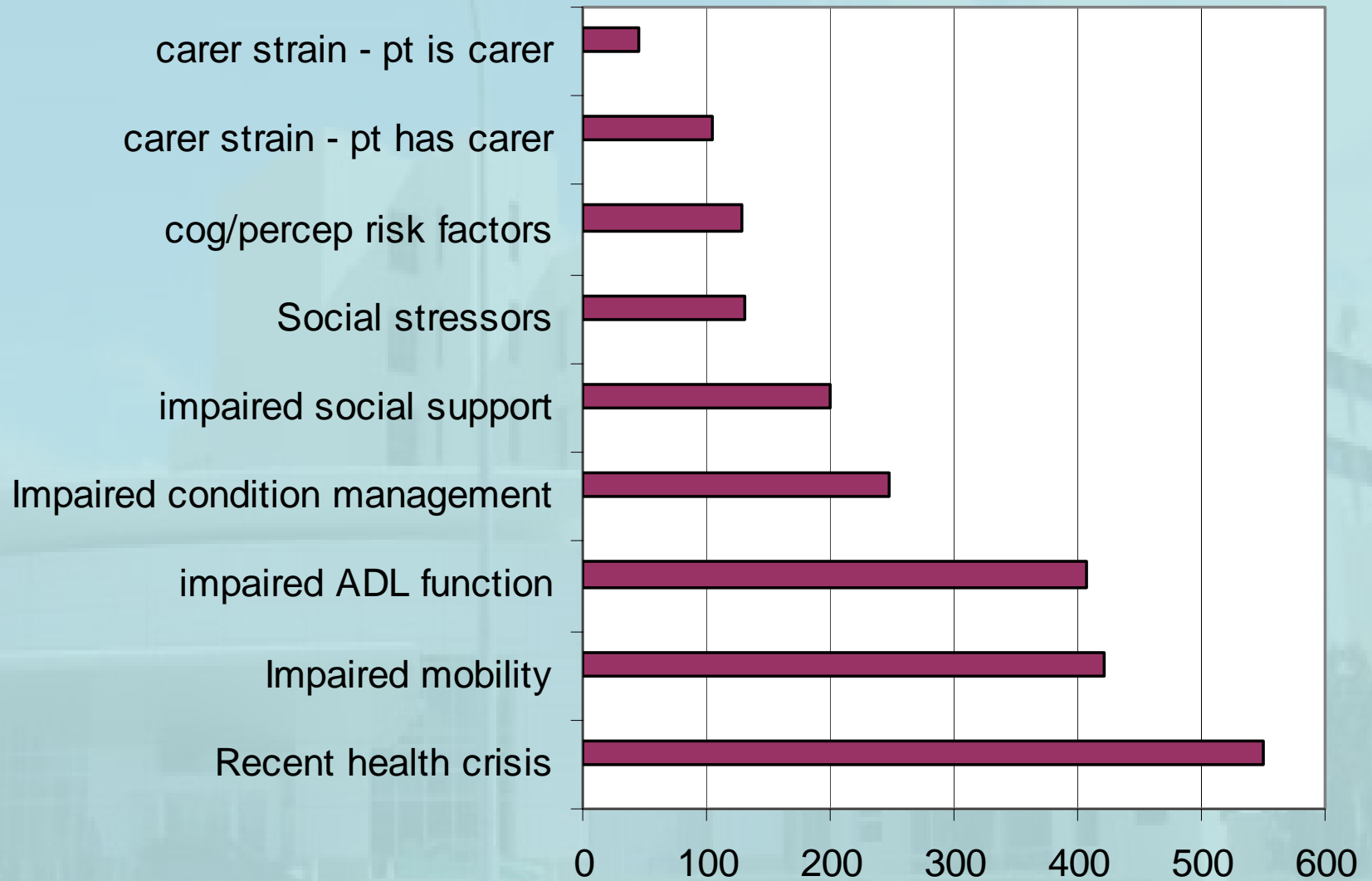
- Enable a partnership between patient/family PHC services to sustain their long term health & wellness

## AGE RANGE



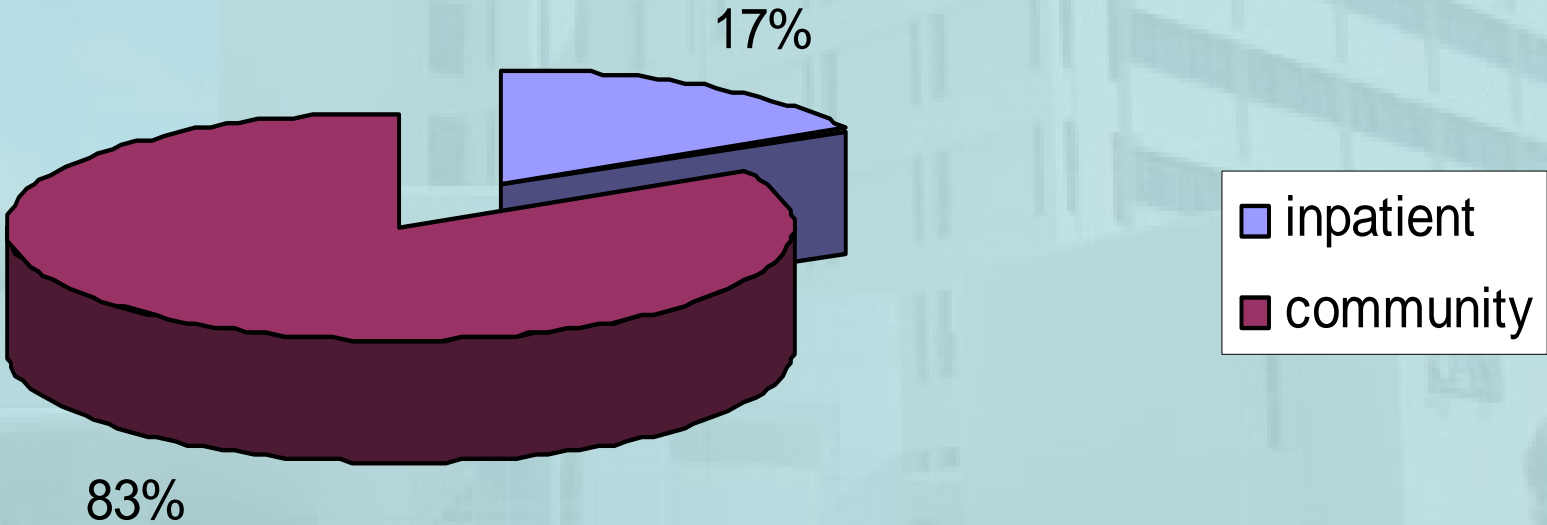
1082 patients seen  
Sept 06 – June 08

# PEDAL FACTORS



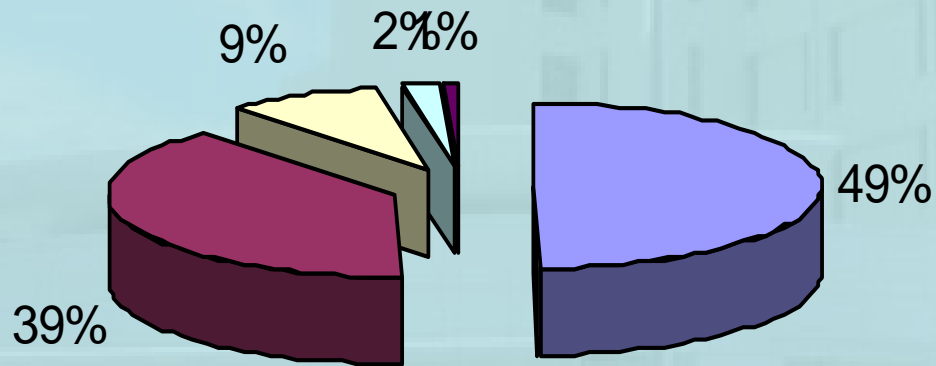
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# CARE DESTINATION



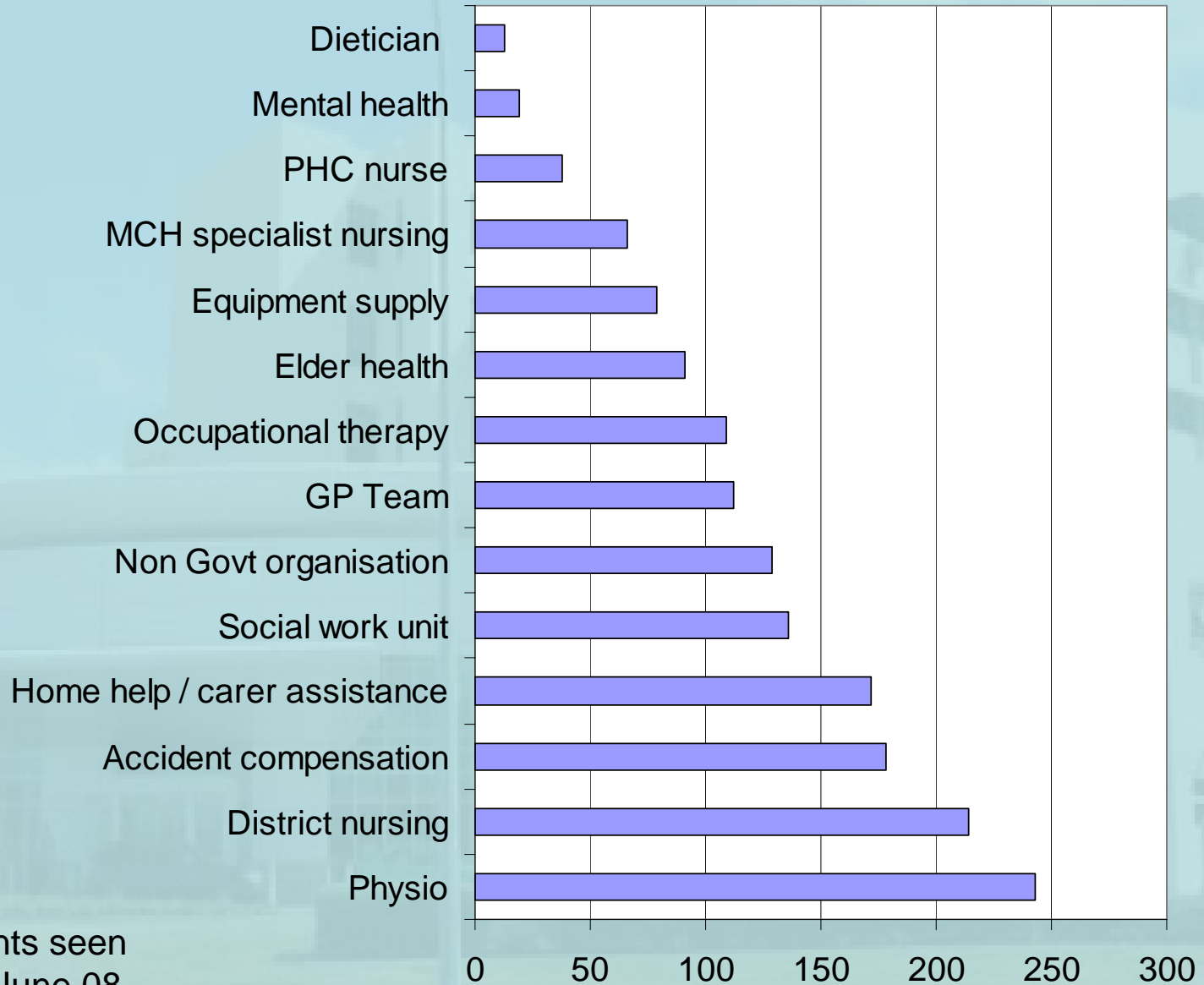
1082 patients seen  
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# ADMISSION REASONS



- Medically unstable
- unsafe mobility
- inadeq formal support
- delayed formal support
- inadeq informal support

# PEDAL REFERRALS



1082 patients seen  
Sept 06 – June 08

## Other key PEDAL patient features

- For 26 % a fall contributed to their ED presentation.
- Only 2.7 % re-presented to ED within 72 hours of PEDAL input.
- 2.7 % had been in hospital within 7 days
- 5.1 % had been in ED in the last 30 days
- Ave PEDAL nursing hrs per patient = 2hrs
- Ave PEDAL social work hrs per patient = 1.3 hrs

# Case study

- 88 year old man who lives with wife in his own home, usually independent with own ADL's
- Pmhx: Multiple MI's, IHD, HTN, CHF, Asthma, Osteoarthritis, Gout.
- Discharged from inpatient services 10 days ago following another MI.
- Post discharge, developed a productive cough & SOBOE

- Diagnosed – viral exacerbation of asthma
- ED arranged for patient to be held overnight in EDOA for joint medical and PEDAL review in am.
- Joint review decision - discharged home
- PEDAL Nurse and Social Worker involved patient and family

# PEDAL issues identified:

- Potential for health deterioration
- Difficulty with ADL's
- Potential for falls due to mobility difficulties
- Carer strain
- Difficulties with self management of his asthma

# PEDAL discharge plan

- Daily DNS visits
- Physio assessment
- Occupational therapist assessment
- Referral for short term home help
- S/W follow up home visit arranged.
- Referral to Asthma Primary Health Care Nurse

# PEDAL follow up two days later

- District nurse confirmed Mr B improving and Mrs B not feeling so overwhelmed
- PEDAL nurse phone call to Mr B revealed he was feeling better
- Reminded of contact by social worker soon
- Primary Health Care asthma nurse will be in contact for education and oversight of his long term condition.
- Mr and Mrs B very pleased with the support they received.

# PEDAL - pulling it all together....

- The PEDAL team brings a PHC approach to an environment not traditionally well resourced for complex discharge planning.
- It's not about quick fix discharges, instead PEDAL focuses on finding out what is really leading to the patient's ED presentation.
- AT& R focus, in contrast to the traditional ED focus.
- PEDAL is a link between PHC and Acute Care. It seeks to find people who may be falling between the gaps.

# Excellence in Primary & Secondary Collaboration & Integration Award



Winner: Post Emergency Department Assessment and Liaison (PEDAL) Service, MDHB. Ann Fowler, Marg Harvey, Annie Small, Denise White

- Combined social work and nursing lens.
- PHC nursing knowledge in the ED setting.
- 24 hour District Nursing Service support.
- Sufficient range of PHC services available
- High commitment to PEDAL from all hospital services.