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CONFERENCE ABSTRACT

Frail Elderly Pilot Programme Connolly Hospital Blanchardstown 2016

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Introduction: The Specialist Geriatric Services (SGS) Model of Care aims to improve quality and efficiency of care for older people with complex health care needs. The Frail Elderly Pilot Programme commenced in Connolly Hospital Blanchardstown (CHB) in January 2016 to achieve these aims. It involves the early identification of the 'frail older person' with confusion, falls, poor mobility, swallowing problems, communication problems, poly-pharmacy, malnutrition and social factors which may warrant a comprehensive multidisciplinary assessment.

Aim: The aim of the pilot programme was to improve the experience of the 'frail older person' in the Emergency Department (ED) and onward patient flow through CHB.

Methods: The Frail Elderly Team was established within the ED and the Acute Medical Assessment Unit (AMAU) in CHB. Patients 75 years and over were screened for frailty indicators during core hours. Patients who presented with frailty received a comprehensive multidisciplinary assessment in the ED with rehabilitation and discharge pathways identified from the initial assessment. Frail Elderly care pathways and guidelines were implemented to improve quality, efficiency and outcomes for this cohort. To facilitate ED discharge, a rapid access pathway to the Day Hospital was established. Close links were forged with the Patient Flow Coordinator and Community Case Managers to facilitate transition of care and safe discharge.

Results: A total of 738 patients received input from the Frail Elderly Team from January to September 2016. Referral reasons included functional, cognitive, social, swallowing, communication, nutritional assessment, falls and poly-pharmacy. Patients were categorised as mildly to moderately frail on average (5.5 Rockwood Clinical Frailty Scale). From January to March 2016 a preliminary analysis of 4AT results indicated 60% were positive for acute delirium +/- cognitive impairment. 31% of those referred to the Dietitian were at high risk of malnutrition according to actual and subjective Malnutrition Universal Screening Tool scores from February to June. Results will be presented from the data gathered from January - December 2016.

Conclusions: The Frail Elderly Team aims to improve the quality and efficiency of care and outcomes for the frail elderly presenting to CHB. From the success of this pilot study, hospital management are continuing with this programme into the new year. The SGS will continue to

provide education and leadership in relation to the identification of the frail older person, CGA and early discharge planning where possible of identified frail older people.

Lessons learned: The Frail Elderly Team members have enhanced their knowledge of each disciplines' role and referral criteria through in-services. Education has been provided by the team to the wider hospital.

Keywords: frail elderly; comprehensive multidisciplinary assessment

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