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CONFERENCE ABSTRACT

Integrated Healthcare for the Frail Older Adult

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Background: In Ireland, the proportion of persons aged over 65 years is set to increase from 11.4% to 18% over the next 30 years1. A significant proportion of older people presenting to hospital settings are frail and less able to adapt to stressors such as acute illness. This increased vulnerability contributes to adverse outcomes such as falls, delirium and increased hospital stays. Comprehensive geriatric assessment has been shown to be effective and improves an older persons chance of maintaining their independance at home after an acute hospital admission2.

Aims: This project set out to improve the experience of care for frail older patients by:

Increasing patient satisfaction

Reduced length of stay (LOS) of 1 bed day for patients over 70 years of age, with no increase in readmission rate

No increase in adverse events

These aims were addressed by establishing a frailty pathway with a particular focus on integration between community and acute services.

Methods: Development and introduction of frailty screening tool for all patients >70 years of age presenting to the hospital.

Designation of a Specialist Gerontology Ward (SGW) within the hospital where frail older patients are cohorted according to an agreed Standard Operating Policy.

Appointment of a nurse specialist in gerontology, to provide initial assessment of those highlighted by the screening tool, and to co-ordinate transition of care to the SGW and back to the community.

Implementation of a daily multidisciplinary (MDT) meeting on the SGW.

Implementation of a weekly integrated care planning meeting involving members of multidisciplinary teams both from the hospital and the community.

Implementation of an interdisciplinary falls programme for frail older patients on the SGW and supported by the community falls service.

A clear focus on admission avoidance where appropriate from the Emergency Department and Acute Assessment Unit.

Implementation of a cross programme governance structure to oversee and drive the project.

Results: A patient centered questionnaire showed an increase in patient satisfaction levels from 67% on the previous ward to 79.6%, 3 months after the SGW opened.

The median length of stay for this cohort of patients reduced from 12.6 days to 10.39 days (17.5% reduction in LOS), with no increase in readmission rates or adverse events. This equates to 695.25 bed days saved over the first 6 months of this project. The turnover (median number of discharges per month) has increased by 59%.

Conclusions: Our integrated care pathyway for older people has proven itself to be of high quality, effective and efficent. This is largely due to improved interdisciplinary teamwork with patient centred care at the core. Limitations of this study are its retrospective nature. We plan to complete a prospective analysis in January 2017. We propose that reinvesting costs saved, back into the frailty pathway, would lead to better outcomes for older people living in our community,

References:

1- HSE National Clinical Programme for the Older Person 2012.

2- Comprehensive geriatric assessment for older adults admitted to hospital. Cochrane July 2011.

Keywords: frailty; interdisciplinary teamwork