National Clinical Programme for Older People (NCPOP) and the Integrated Care Programme for Older Persons (ICPOP)

Transforming Care of Older People in Ireland

IGS UPDATE
September 2017
Welcome and Thank You

We would like to thank the IGS for giving us the opportunity to include some information from the National Clinical Programme for Older People (NCPOP) and the Integrated Care Programme for Older persons (ICPOP) in your delegate pack.

The NCPOP started in 2010, and progress and momentum are increasing. It is great to see the focus in the IGS meeting this year in many of the posters and presentations on various elements of the programmes – from acute care on specialist wards, pioneer sites, rehabilitation, outreach, day hospitals, and many more. You will get access to the Acute Model of Care and CGA documents at: http://www.hse.ie/eng/about/Who/clinical/natclinprog/olderpeopleprogramme/models

The key steps and challenges of improving integrated care between community and hospital services is one which we continue to work on with you. None of this would be possible without the huge contribution made by all of you in your local units, and also with those of you who give up your time to contribute to the various advisory groups within the clinical programme you have joined. So a sincere thanks to all of you for your contributions.

At this year’s IGS in addition to the many presentations on elements of the programmes, our director of nursing Deirdre Lang, will give one of the key note lectures on “Changing Perspectives in Gerontology: “The Tipping Point”. We will also update you on recent and planned developments around the programmes during the update session on Saturday morning, including “the Frailty Education Programme”.

On May 23rd 2017, the NCPOP and ICPOP hosted the 3rd “Transforming Care of Older People in Ireland” conference in the Royal College of Physicians of Ireland, with over 200 delegates in attendance. It was a hugely successful meeting and provided excellent opportunities for information sharing and networking. Clinical and service leaders from around the country provided examples of clinical excellence and innovations and highlighted key areas for improvement in order to advance care services for older people. The need to focus on person-centred care, the importance of community services, respite services and homecare to support older people at home, and to aid the transition from hospital back into their community and maintain good health for as long as possible were highlighted.
Included in this pack are some of these highlights. The meeting will be held again in May next year, so keep a look out for it!

This is truly a multidisciplinary team effort and we will continue to work with you on service innovation and development. Advocating for the resources the older person in Ireland needs to stay as well as possible, for as long as possible in their own home, is a role that belongs to us all. The more effectively we work together, the more likely we are to help meet the challenges and maximize the opportunities that ageing well and frailty have both for people themselves and health care delivery in Ireland.

We would like to take this opportunity to thank and acknowledge the huge amount of work undertaken by many groups and individuals to advance the work of the NCPOP and the ICPOP; the clinical advisory group, working advisory group, many sub-groups for their clinical expertise and contributions to the programmes. This expertise and guidance is paramount in designing and developing service provision for older persons care in Ireland, and developing new ways of working together.

Thank you for taking the time to look through our information pack, enjoy the meeting and the networking. If you have any feedback or would like to become more involved in one of our working groups (we have several interprofessional subgroups) please contact our programme manager Helen Whitty, at helenwhitty@rcpi.ie

Yours sincerely,

Dr Diarmuid O’Shea
Clinical Lead, NCPOP

Dr Siobhán Kennelly
National Clinical Advisor
Lead, Social Care Division
Since September 2016, the National Clinical Programme for Older People (NCPOP) has completed a number of key activities and new developments, to support the uptake of the Specialist Geriatric Model of Care (2012), and align the work of the Integrated Care Programme for Older Persons (ICPOP), to deliver improved health and social care for older people in Ireland.

Transforming Care for Older People in Ireland Conference
In May 2017, the NCPOP and Integrated Care Programme for Older Persons (ICPOP) hosted the 3rd Transforming Care of Older People in Ireland conference, in the Royal College of Physicians of Ireland. It was a hugely successful meeting with over 200 delegates in attendance, and provided excellent information sharing and networking opportunities.

The conference theme focused on frailty and integrated care, with guest international speakers, Prof Anne Hendry and Dr. Jay Banerjee, providing the keynote address during the morning session on strategic development; challenges and progress. Discussions related to the patient’s journey, developing frailty pathways, insights from TILDA, the Scottish experience of integrating care and implementing integrated care pathways for vulnerable older adults. The afternoon session on service integration; excellence and innovations, clinical and service leaders from around the country provide local examples of making the change happen, new ways of working, service development, nursing home outreach and a site example of integrated care team actively at work.

Selection of images from the day

**Left to Right:** Dr Colm Henry, Prof. Anne Hendry, Mr Colm O’Reardon, Dr Jay Banerjee, Dr. Siobhan Kennelly, Ms Hazel Luskin Glennon, Prof Rose Anne Kenny, Dr Diarmuid O’Shea.

**Left to Right:** Dr Diarmuid O’Shea, Clinical Lead National Clinical Programme for Older people and Registrar RCPI, Mr Colm O’ Riordan, Deputy Secretary, Policy & Strategy /DOH, Dr. Jay Banerjee Consultant in Emergency Medicine & Associate Medical Director for Clinical Quality & Improvement NHS Trust, Prof Rose Anne Kenny, TILDA, Professor of Geriatric Medicine, TCD.
Frailty Education Programme

In October 2016, the NCPOP developed a National Frailty Education Programme, in collaboration with The Irish Longitudinal Study on Ageing (TILDA), and sponsored by the Office of the Nursing and Midwifery Service Director (OMNSD). This initiative is supported by cross programme collaboration with the Acute Medicine and Emergency Medicine Programmes, and is being piloted in three Hospital Groups (HGs) and corresponding Community Healthcare Organisations (CHOs) during 2017 (see appendix one).

The programme aims to provide healthcare professionals with an enhanced understanding of frailty and frailty assessments, thereby ensuring earlier recognition of frailty, improved healthcare management and better health outcomes for frail older adults.

The pilot phase commenced February 2017 and has two consecutive phases at each location (HG and CHO):

- **Phase 1**: nominated facilitators from HG & CHO attend TILDA to complete a one day Insights into Frailty Programme.
- **Phase 2**: nominated facilitators from HG & CHO provide “Fundamentals of Frailty” education programme locally in their/across their organisation and will establish a local governance group to support the roll out of the programme locally.
  - Where there is a local steering group already in place for Integrated Care (through the Integrated Care Programme for Older People), this governance group would undertake this role.
  - It is envisaged that local innovation will drive how these groups evolve.

The programme will be piloted with the development of up to a 100 nurse facilitators. However, it is proposed to use the findings of the initial programme to inform the development of an Interdisciplinary frailty education programme and to explore the development of an e-learning blended platform.

**Integrated Care and the National Working Group for Older People (NWGOP)**

In order to support the implementation of the Integrated Care Programme for Older Persons (ICPOP) and build on the existing work of the NCPOP, a new governance structure was established in 2016, which includes a National Working Group for Older Persons (NWGOP). This group meets on a monthly basis to align dual objectives, while continuing to link with their existing multi-disciplinary and inter-departmental groups to facilitate the joint implementation of programme outputs. In addition to developing clinical guidance, running educational events and undertaking joint site visits, the team is actively involved in shaping national policy and promoting the transformation of care for older persons in Ireland.

**Framework for Integrated Care**

A key component of the integrated Programme is the development of a 10-Step Framework which sets out the planned route of travel for the integration of health and social care for older people nationally (please refer to appendix two). The emphasis is on a population health approach that requires Community Healthcare Organisations, Hospital Groups (and partners) to plan and implement a joint population planning approach to service development and delivery.
This incremental framework approach has at its core, a focus on evaluation of structure (governance and teams in place), process (measuring care processes, transitions between care) and outcome (patient centred outcome measures and value based care) and is underpinned by ICT, Financial and Workforce enablers. The current focus is on the development of 12 pioneer sites nationally (6 in 2016 and 6 in 2017) outlined in figure one below.

**Figure 1 - Integrated Care Pioneer Areas 2016 - 2017**

**Comprehensive Geriatric Assessment (CGA) Framework**
The NCPOP “Guidance framework document on Comprehensive Geriatric Assessment (CGA)” was launched in May 2016 (see appendix three). The Programme is currently supporting the implementation and understanding of CGA to inform healthcare staff about the multi-assessment and management of the care of older people. CGA has the potential to improve the care that older people receive in hospital and reduce unnecessary hospital admissions, lengths of stay and readmissions. The awareness and understanding of CGA will be further progressed in 2017 through the Frailty Education Programme mentioned above.

**Clinical Pathways to Support Specialist Geriatric Model of Care (2012)**
A number of clinical patient care pathways, in collaboration with other clinical Programmes were progressed, to assist healthcare professionals to assess and treat older patients appropriately. The implementation of the “Early Identification and initial management of Delirium in the Emergency Department/Acute Medical Assessment Unit” pathway, the development of Delirium Management on the Acute Ward ED/AMAU pathway (see appendix four) and the development of the Syncope/Transient Loss of Consciousness ED/AMAU which will be disseminated over coming months.
Strategic Vision & Educational Framework for Nursing Staff working with Older People

In 2016, the NCPOP in collaboration with the Office Nursing Midwifery Services Directorate (ONMSD) commissioned a research project from University College Cork, to determine the knowledge, skills and competence required to produce a nursing workforce that can provide quality person-centred care to older people across the spectrum of healthcare. The aim was to develop an educational framework to enable nurses to acquire and maintain the necessary knowledge, skills and competence, at the appropriate level to deliver care to older people, throughout the Irish Health Service. The strategic vision and educational framework will be available by the end of 2017.

National Transfer Tool

Building on work undertaken by St Vincent’s University Hospital and St Michaels Hospital, the NCPOP are aiming to agree and standardise a National Transfer Tool for use in transferring residents from residential services to acute hospitals. The focus of this work is to ensure that information sent by transferring organisations with their patients/residents provides the necessary information needed to ensure care is safe, effective and person-centred. The programme to date has analysed 92 letters from older person services (public & private), which suggests that there continues to be a wide variance in the information provided upon transfer of the resident to the acute hospital. A number of focus groups have also been undertaken. Findings suggest conducting a systematic review and evidence base approach to transfer of nursing information between healthcare settings. The NCPOP are currently scoping out potential funding for research to progress.

Community Beds Report

The community beds report, building on bed types referred to in the Specialist Geriatric Model of Care Document (2012), providing guidance on governance, staffing and the use of community hospital beds was completed in 2016 and submitted to relevant HSE divisions.

Specialist Geriatric Services Model of Care, Part 2: Mental Health Service Provision

Specialist Geriatric Services Model of Care, Part 2: Mental Health Service provision, relates to the provision of specialist mental health services for older people. These services interact with and complement general medical services for older people in primary and secondary care. The majority of older people with mental health issues are managed by a broad range of disciplines in the community with referral to specialist mental health services only if clinically necessary. The Mental Health Model of Care led by Dr Margo Wrigley, in collaboration with the HSE Mental Health Division, will be published in 2017.

What Matters to You (WMTY)

WMTY is a quality improvement initiative to enhance compassionate person-centered care and patient experience. In 2016, the NCPOP, in collaboration with the Quality Improvement Division (QID) and the Irish Hospice Foundation (IHF), worked with two acute hospitals, St Vincent’s University Hospital, and Regional Hospital Portlaoise, to pilot the introduction of WMTY in one ward in each hospital. A suite of documents were developed to provide guidance and information; WMTY logo, WMTY board, frequently asked questions, patient information leaflet and WMTY patient stories. Pilot sites were evaluated in
2017 and the findings will be issued by the end of 2017 with roll-out to other wards and hospital sites explored.

A Spotlight on Excellence and Innovations

Specialist Geriatric Services Model of Care Part 1: Acute Service Provision
(HSE and RCPI, 2012)

Over the past few years, many local initiatives have adopted the Specialist Geriatric Services model of care (2012) and are commencing pathways to improve the care provided to the frail older patient. The 10 steps integrated care framework for older persons (HSE and RCPI, 2016) builds on this work with the development of 12 pioneer sites nationally (6 in 2016 and 6 in 2017). We are delighted to highlight three examples of local service implementation from Dublin, Galway and Kilkenny.

Frailty Intervention Therapy (FIT) Team
Beaumont Hospital, Dublin
(Submitted by Paul Maloney on behalf of the FIT team)

The Frailty Intervention Therapy (FIT) Team was established in Beaumont Hospital’s (BH) Emergency Department (ED) in September, 2015. Aligned with organisational priorities, the FIT team service enables early identification of need through screening of all patients, over 75 years, presenting during core working hours, 08.00 – 17.00 Monday to Friday.

This FIT team consists of Physiotherapy, Occupational Therapy, Medical Social Work, Speech and Language Therapy, Dietetics and Pharmacy, and has built strong links with the ED Nursing and Medical team. Since September, 2015, over 9,000 patients have been screened for frailty by the FIT Team. Approximately 105 patients are assessed by the FIT team each week in the ED.

The inter-disciplinary screening process is conducted on all patients age 75 and over who present to ED within core working hours and under age 75 referred by ED medical and nursing colleagues. Screening is usually initiated within 1 hour of presentation, unless contraindicated medically. This facilitates timely initiation of the appropriate treatment pathway and robust handover. Rehabilitation commences in the ED, preventing unnecessary physical and cognitive deterioration which can be caused from a delay in accessing HSCPs as patients await admission to the ward. Since June 2017, the FIT Team has jointly developed an Electronic Patient Record with Beaumont Hospital’s IT Department, ensuring further improvements in handover efficiency and patient safety.

An outreach Integrated Care Service is offered patients identified as appropriate for discharge with follow-up services. A recent test of this service model, implemented in partnership with Dublin North Services (CHO 9) found that 55 patients avoided admission by being safely discharged and maintained at home. Remarkably, 700 bed days were saved in this brief five month test period.
Key to the success of this model;

- A rapid response (treatment at home within 24 hours),
- Intensive Occupational Therapy and Physiotherapy (capacity allowing) for up to four weeks
- Case management, working closely with PHN and GP colleagues.

Admission avoidance, when appropriate, is critical in order to prolong independent living in the community. This early work continues to be most beneficial in informing the model for the new Integrated Care Team, recently initiated in Dublin North.

A Novel Comprehensive Geriatric Care Pathway
University Hospital Galway

(Submitted by Consultant Geriatrician Stephanie Robinson on behalf of the MDT team)

Service Model
Over the last six month, we have developed a multi-disciplinary specialist geriatric team (MDT) integrating geriatric medicine, nursing and health and social care professionals to provide rapid access to comprehensive geriatric assessment (CGA) in the acute care setting. This frailty service model is grounded in a specialist frailty team taking over care of highly vulnerable older adults with a hallmark service delivery of daily, brief MDT meetings and MDT delivered CGA to plan care and goal set.

Integrated team members
The specialist geriatric team is led by a consultant geriatrician with a clinical nurse specialist, two non-consultant hospital doctors, a physiotherapist, an occupational therapist and a medical social worker.

Screening process
Our service model provides screening to all patients aged ≥ 75 years, medically admitted as unscheduled care via the Emergency Department. The frailty screening tool used is the PRISMA 7 score and is considered positive if score ≥ 3. The frailty screening process is led by a clinical nurse specialist in gerontology and supported by the MDT. This screening process is enhanced by details of medical status at time of presentation and a brief social/functional history.

Patient Selection
In the initial 6 months period of this newly developed model 611 patients were screened and we provided direct access to CGA with take-over of care by a specialised frailty team for 26% of these. Other outcomes were as follows; Not screening frail with PRISMA 7 score < 3 (15.8%), medically too unwell to engage in CGA (41.8%) and unable to accept care due to service capacity (16.4%).

Key Performance Indicators
Service key performance indicators include measures of patient experience, time to complete comprehensive geriatric assessment, clinical frailty scale score at baseline/admission/discharge, preserving of functional status as measured by clinical frailty scale during inter-current illness, enhanced home supports, time spent at home and discharge destination.
Geriatric Emergency Medical Service (GEMS)
St. Luke’s General Hospital, Kilkenny
(Submitted by Consultant Geriatrician Emer Ahern on behalf of the GEMS team)

Frailty is a long-established clinical expression that implies concern about an older person’s vulnerability and prognosis and may be defined as a clinical state of increased vulnerability resulting from age-associated decline in reserve and function across multiple physiologic systems (Qian-Li Xue, 2011). Older people with frailty are a complex cohort at high risk of adverse outcomes and high resource users.

The Irish Longitudinal Study on Ageing (TILDA) (The impact of frailty on public health nurse utilisation, 2016) reported 31% of the Irish older population aged 65 and over were robust, 45% were pre-frail and 24% were frail. Weighted estimate of frailty in our CHO area (5) is estimated at 22.9% (Tilda, wave 1).

We launched our acute frailty service (GEMS) in Kilkenny on 21st February 2017. The core GEMS team is based in AMAU and ED and includes;

- Clinical nurse specialist (Jane Nolan)
- Senior physiotherapist (Helen Fitzgerald)
- Occupational therapist (OT) (Danielle Reddy)
- Consultant Geriatrician (Emer Ahern)

Aim and objectives of GEMS service:

- To optimise care and outcomes for all older people with frailty attending SLGH
- To screen all patients aged 75 and over who attend Acute Medical Assessment Unit (AMAU) and Emergency Department (ED) using a 3 question tool ‘Variable Indicative of Placement risk’ (VIP) (The VIP is a very simple and easy-to-use screening instrument to identify patients who are at risk of problems at discharge. It asks three simple questions about frailty factors already existing before admission.)
- To provide interdisciplinary Comprehensive Geriatric Assessment (CGA) for patients who are positively identified within 72 hours of attendance.
- To increase discharges from acute floor and reduce numbers of patients admitted
- To reduce re-attendance rates of non-admitted patients
- To reduce length of stay of admitted patients
- To reduce re-admission rates of admitted patients
- To reduce institutionalisation

GEMS so far...

- Nearly 100 patients aged 75 and over attend AMAU and ED every week.
- 100% of those who attend are screened using the VIP tool on AMAU and ED triage.
- 40% identified as at risk (average age is 85 years).
- 67% received CGA and on average within 1.63 days (Patients who were admitted and discharged out of service hours did not receive CGA).
• Admission conversion rate is 56% and average length of stay is 8 days.
• 45% were identified as ‘Vulnerable to Moderately Frail’ (4-6) on Rockwood Clinical Frailty Score (CFS) and 31% as ‘Severely Frail to Terminally Ill’ (7-9).
• Other referrals included Pharmacy (69%), Physiotherapy (74%), OT (57%), Dietician (32%), Speech and Language Therapy (16%), Discharge Planner, Public Health Nurse, Tissue Viability Nurse, Palliative Care Service, Falls Clinic, Social Services.

Critical to the success of the service is the mandatory screening on triage and the interdisciplinary culture of the team. We hope to expand our service to include an ambulatory assessment unit and an in-patient acute frailty unit.

Your Involvement Matters
If you would like to write an update for our next spotlight edition, please indicate your interest to the programme manager, helenwhitty@rcpi.ie
Acute Model of Care (2012) Key Recommendations:

The SGS model outlines a number of key recommendations outlined below, for the establishment of a Specialist Geriatric Service to achieve measurable improvements in outcomes for frail older people living with frailty. The recommendations follow the end to end pathway/patient journey from their home, through primary care, acute care and discharge home (or other).

<table>
<thead>
<tr>
<th>Pathway stage and reference section Acute Model of Care</th>
<th>Recommendations</th>
<th>Prompts</th>
</tr>
</thead>
</table>
| Identifying people with frailty in ED/AMU Section 4.5.3.1 (Page 22) | Each ED/AMU in conjunction with Specialist Geriatric Service will have in place an agreed process for identifying/triaging the older adult. | • Is there a process in place to identify frailty?  
• Who takes the lead on this process? Is it interdisciplinary? |
| Role of SGS in ED/AMU Section 4.5.3.2 (Page 23) | The SGS will link with the ED/AMU when an older person is identified as having frailty and requires referral to the SGS for CGA/admission to the SGW | • Has an assessment area been allocated to the older adult with frailty in the ED/AMU?  
• Is there a specific pathway in place for the delivery of acute medical care to the older person with frailty with a clinical lead?  
• Is there a formal SGS pathway that begins in the ED/AMU?  
• Have staff completed the National Frailty Education Programme? |
| Referral to the SGT Section 4.5.4 (Page 26) | Each SGS will have defined and agreed criteria with their ED/AMU and community that determines whether an older person should be referred to the SGT | • Is there a dedicated core team?  
• Are there formal, defined and agreed criteria for referral? |
| Patient referral and Intervention Pathway Section 4.5.4 (Page 26) | Once referred decisions about the appropriate SGS to meet the patients needs will be made by a senior professional within a specified timeframe | • Does this form part of a formal SGS pathway?  
• Are there specific pathways (e.g. Frailty/Delirium/Falls or others)? |
| Comprehensive Geriatric Assessment Section 4.5.5 (Page 27) | All older people identified as frail to have a timely CGA performed and documented in their permanent health record that is accessible to both primary and secondary teams | • Does CGA form part of a formal SGS pathway?  
• Does CGA lead to the development of a coordianted and integrated plan for treatment and long-term follow-up?  
• Are all components of CGA available? |
| Specialist Geriatric Ward (SGW) Section 4.5.6 (Page 28) | Each hospital receiving acutely ill older adults must have a dedicated SGW with appropriate staffing levels and a designated Interdisciplinary team | • Has the need and capacity for SGW been determined? (# frail (24% of>70 ED admissions) x 18 days?  
• # older person with frailty admitted to SGW? |
### Inpatient Rehabilitation

**Section 4.5.7** (Page 29)

- Does admission to SGW form part of the care pathway?
- Is there an inclusion/exclusion criteria to SGW?
- Is the SGW adequately staffed with appropriately skilled/educated cohort of SGT (Chapter 6)?

**Each hospital had access to onsite and off-site rehabilitation beds and delivers a structured rehabilitation programme for older people**

- Is there access to rehabilitation onsite?
- Is there access to rehabilitation off site?
- Is there a referral pathway established and agreed across the SGS?
- Is the rehab programme provided consistent with the description of rehabilitation as outlined in the Acute Model of Care (Chapter 5)

### Discharge Planning

**Section 4.5.8** (Page 29)

- Is there a systematic approach to discharge of the older person with frailty that is consistent with the Acute Model of Care and the Code of Practice for Integrated Discharge Planning?
- Are discharge plans (which include EDD and discharge destination) initiated within 24 hours?
- Are EDD’s proactively managed and how is this evident?
- Are there regular Interdisciplinary team discharge planning meetings?
- At what stage does planning with the family commence?
- How do you flag a delayed discharge?
- What are the causes of delayed discharges in your site?
- Do patients return to the acute service upon completion of rehabilitation (prior to accessing HCP)?
- Do the hospital employ a discharge by 11am policy?
- Are discharge destinations recorded?
<table>
<thead>
<tr>
<th>SGS Outpatient &amp; Rapid Access Clinic</th>
<th>Each SGS will provide an outpatient service which encompasses sub-speciality clinics with rapid access slots for urgent referrals</th>
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</thead>
</table>
| **Section 4.5.9** *(Page 30)*      | • What OPD services are provided for older people?  
• What nurse-led clinics are provided?  
• Are referral pathways to OPD clinics outlined clearly?  
• Are rapid access slots available for referrals from ED/AMU/SGS/Community?  
• Is there a case management approach to manage the needs of older people with complex needs across acute and community service interface? |
| Ambulatory Day Hospital on the acute site | The DH will be the setting for acute ambulatory services. It will also function as the co-ordination, information and training hub for services for older patients, supporting integration between hospital and community based services. In addition it will act as a resource for others involved with the care of older people. |
| **Section 4.5.10** *(Page 30)*      | • Are referral pathways to the DH outlined?  
• Are rapid access slots available for ED/AMU/SGS/Community?  
• Is CGA carried out in the DH?  
• Is access to diagnostics available?  
• Is there an MDT in place in the day hospital? |
| Outreach services e.g. to Long-term care residential facilities | Each SGS will provide an outreach service, prioritising residents in long-term care referred by the GP or medical officer. The outreach service will also liaise with Psychiatry of Old Age (POLL) and support training and education of community based staff |
| **Section 4.5.11** *(Page 31)*      | • Does the SGS provide an outreach service to long-term care facilities as outlined in the Acute Model? |
| Working with community services | The establishment of SGTs in acute hospitals will facilitate communication with GP’s and PCT’s. A single access point will be established to support referral. Outcome of hospital assessment and plan of care will be communicated in a timely manner to referral source. |
| **Section 4.5.12** *(Page 32)*      | • Is communication across services working effectively in relation to the referral and discharge of the older person with frailty?  
• Is there access to a case management approach for older people with complex needs? |
Appendix 1 - Frailty Education Programme

- Collaboration with NCPOP, TILDA and sponsored by OMNSD.
- Supported by cross Programme collaboration with the Acute Medicine and Emergency Medicine Programmes
- Commencing Feb 2017 – pilot in three Hospital Groups (HGs) and corresponding Community Healthcare Organisations (CHOs) areas.

Programme Aim
The programme aims to provide healthcare professionals with an enhanced understanding of frailty and frailty assessments, thereby ensuring earlier recognition of frailty, improved healthcare management and better health outcomes for frail older adults.

Methodology
The programme has been developed to demonstrate proof of concept and to inform the roll out of the frailty education programme nationally, the development of an interdisciplinary education approach, and the development of an e-learning blended platform. The initial pilot has been funded to support the development of facilitators in frailty education from nursing. However, the aim for this programme is an Inter-professional education approach to support the comprehensive assessment and care of the older adult with frailty.

The programme methodology consists of two distinct elements, both of which support the sustainability of the education programme into the future.

Part 1: TILDA Insights into Frailty Education Programme
The following methodology has been applied to the development of the National Frailty Education Programme Facilitators (Figure 1). It is of note that the “Insights into Frailty” programme is being evaluated to level three of the Kirkpatrick Model using a pre and post online survey and a post-programme evaluation form.

Figure 1: Three Step Facilitator Programme

Step 1: TILDA
32 nurses (in cohorts of 8) from across the Hospital Group & Community Health Organisations attend TILDA for “Insights into Frailty”; a one-day education programme

Step 2: Facilitator Network Workshop Day 1
Each network (Facilitators from acute hospital and corresponding PHN, ID services and Residential Care) meet to scope out/ complete a SWOT, risk register and stakeholder analysis for the local implementation of the education programme
Each facilitator and their nominating manager will complete a memorandum of understanding with the NCPOP

Step 3: Facilitator Network Workshop Day 2
• Education resource pack and handbook
• Database
• Evaluation methodology (all components developed by NCPOP)
Role of the Facilitator Locally

Each facilitator will work within a local network (Acute hospital, PHN, Residential) to:

- Provide education programmes across the multi-disciplinary team locally. Where possible the acute hospital should provide the education in the CHO and the Nurses in CHO should support the acute hospital education programme.
- Maintain a database of locally trained staff
- Participate/advise on a local governance group

Part 2: Local Governance

Where not already in place, through the auspice of the Integrated Care Programme for Older People, a local governance group will be established to ensure sustainability by promoting, supporting, delivering and evaluate the frailty education Programme and agreeing the service outcome evaluation measures.

**Suggested Membership:**
(whose will be determined locally)

<table>
<thead>
<tr>
<th>Member of Senior Management Team (e.g. Operations Manager or General Manager)</th>
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<tbody>
<tr>
<td>Consultant Geriatrician</td>
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<tr>
<td>Senior Decision Maker Emergency Department (ED)</td>
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<tr>
<td>Senior Decision Maker Acute Medical Assessment Unit (AMAU) / Medical Assessment Unit (MAU) / Acute Medical Short Stay Unit</td>
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<tr>
<td>Nursing Management (e.g. Director of Nursing Acute Hospital and Older Persons Services DPHN, Assistant Director of Nursing, CNM3 ED&amp;AMU)</td>
</tr>
<tr>
<td>Frailty Facilitators</td>
</tr>
<tr>
<td>Case Manager Older Persons (if in place)</td>
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<tr>
<td>Health and Social Care Representative</td>
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<tr>
<td>Service Manager (Acute and Community)</td>
</tr>
<tr>
<td>Practice Development Co-ordinators or Clinical Facilitator</td>
</tr>
<tr>
<td>Director of Centre for Nursing and Midwifery Education (CNME)</td>
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</tbody>
</table>

**Other:**

a) To be determined locally e.g representation from local steering group for Integrated Care Programme Older Persons where in place and not already represented through any of the designated roles above.

b) In time, per network, Lead Frailty Education Co-ordinator

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**The Local Governance Group will:**

- Appoint a local lead for communication and reporting purposes
- Ensure formal governance arrangements at management level are in place in each sector to support the roll out of the frailty education programme locally
- Ensure there is commitment to release nursing staff to attend Frailty Education Programmes
- Ensure there is commitment to release the Facilitators to deliver Frailty Education Programme locally (See Memorandum of Understanding)
- Agree a timetable for education sessions with local Facilitators
- Support an integrated approach to education by rotating Facilitators across hospital, public health and residential care
- Agree the assessment tool for use in screening for frailty across services locally and referral pathways for the older person living with frailty
- Ensure formal engagement process with local steering group for Integrated Care Programme for Older Persons regarding posts identified for training and outcomes where this structure is in place
- Ensure support for database input and reporting
- Agree KPIs that are aligned to the NCPOP acute model of Care (2012)
Appendix 2 – Integrated Care Framework

10-Step Integrated Care Framework for Older Persons

1. Establish Governance Structures
2. Undertake Population Planning for Older Persons
   - Frailty Prevalence
     - 11% Severely Frail (Very High Risk)
     - 21% Moderate Frailty (High Risk)
     - 36% Mild Frailty (Medium Risk)
     - 32% Fit (Minimal Risk)
3. Map Local Care Resources
4. Develop Services & Care Pathways
   - Rehabilitation
   - Ambulatory Day Care
   - Acute Care
   - Nursing Homes
   - Dementia
   - Falls etc.
5. Develop New Ways of Working
   - New roles including care management approach for long term complex needs in reach and outreach
6. Develop Multidisciplinary Teamwork & Create Clinical Network Hub
   - Co-ordination between care providers
7. Person-centred Care Planning & Service Delivery
8. Supports to Live Well
   - Enable older persons to live well in the community
     - Community Transport
     - Social Activities
     - Home modifications & handy person
     - Medication Management
     - Shopping
     - Harness Technology
     - Support centers
     - Information & Advice
9. Enablers
   - Develop workforce
   - Align finance
   - Information systems
10. Monitor & Evaluate
    - Track service developments
    - Measure outcomes
    - Staff and service user experience
Appendix 3 – Comprehensive Geriatric Assessment (CGA)

What is a Comprehensive Geriatric Assessment?
Comprehensive geriatric assessment (CGA) is an organised approach to assessment designed to determine an older person’s medical conditions, mental health, functional capacity and social circumstances. Its purpose is to develop and implement a coordinated and integrated plan for treatment, rehabilitation, support and long term follow up. CGA is based on the premise that a full evaluation of a frail older person by a team of healthcare professionals may identify a variety of treatable health problems, resulting in a co-ordinated plan and delivery of care leading to better health outcomes.

The 4 Main Dimensions Covered in CGA should Include:

- Physical Assessment
  - Presenting Complaint
  - Past Medical History
  - Medication Reconciliation and review Nutritional Status
  - Alcohol
  - Immunisation Status
  - Advance Directives
- Functional Assessment
  - Activities of daily living
  - Balance
  - Mobility
- Psychological Assessment
  - Cognition and Mood
- Social Assessment
  - Living Arrangements
  - Social Supports
  - Carer Stress
  - Financial Circumstances
  - Environment

‘a multidimensional, interdisciplinary diagnostic process to determine the medical, physiological, and functional capabilities of a frail older person in order to develop a coordinated and integrated plan for treatment and long-term follow up’

For access to the detailed guidance document on CGA, click below link:
http://www.hse.ie/eng/about/Who/clinical/natclinprog/olderpeopleprogramme/resources/ClinicalGuidelines.html
Appendix 4 – Delirium Pathway (ED/AMAU)

Early Identification and Initial Management of Delirium in the Emergency Department / Acute Medical Assessment Unit

Introduction: Delirium is an acute change in cognitive function that has an organic cause and is likely to be reversible or preventable. All patients aged 265 years require screening for delirium on arrival to hospital. Whenever possible get a collateral history. If cognitive impairment is new – ALWAYS THINK DELIRIUM

Older Adult (>65) presents to ED/AMAU
Nurse Assessment after Triage: Perform “4AT” Delirium Screen

Result of 4AT

| ≥4 | Possible Delirium: Assign Triage 2 |
| 1-3 | Possible Cognitive Impairment |
| 0 | Delirium or severe cognitive impairment unlikely (but delirium still possible if information incomplete - use clinical judgment) |

No evidence of delirium
Proceed with admission/discharge plan, as per assessment
Ensure documentation of cognitive status on ED/AMAU Notes
If any concerns about cognitive impairment consider arranging follow-up via GP

Possible Delirium is a Medical Emergency*

Flag for ADMISSION
1. Discuss diagnosis with senior doctor and nurse in ED/AMAU
2. Discuss diagnosis with care/relative
3. Start search for causes of delirium (Remember there is frequently more than one - see Checklist Box on right)

Ensure admitting team know that Delirium is suspected

*Delirium has a high mortality and the vast majority of these patients will need admission. Exceptionally and only after senior discussion should a patient with delirium be discharged.

Patient Flow to source Urgent Bed
This patient will require enhanced supervision while in ED e.g. increased falls risk, wandering

Reduce Delirium in ED
Avoid sedatives, unless distressed and/or combative and felt to be a threat to themselves or others
Avoid physical restraints and use of urinary catheters, if possible
Ensure adequate fluids/nutrition (ensure accessible drinks/snacks, if appropriate)
Avoid constipation
Promote relaxation and sufficient sleep in a quiet area
Early and regular mobilisation
Regular reality orientation using visual and auditory aids
Encourage independence with Activities of Daily Living
Manage any pain, using dementia friendly pain score e.g. PAINAD
Medication review

Managing someone with delirium who is distressed and/or combative and felt to be a threat to themselves or to others

1. ALWAYS try to deescalate the situation first. Explain gently what is happening, re-orientate. Try to nurse in a quiet area and consider the need for ‘one to one’ care.
2. If restraint with medication is needed (only if patient or others are at risk OR essential care is compromised) use small doses and increase gradually. Try ORAL therapies first e.g. Lorazepam 0.5-1mg prn, max 2mg in 24 hours. Should not exceed 2mgs without discussing with senior clinician or Old Age Psychiay/Geriatrician where available. Consider an antipsychotic agent in those with psychotic symptoms. Rivastigmine as 1st line antipsychotic; 0.5mgs OD and increased gradually, but not beyond 2mgs/24 hours without guidance from senior clinician or Old Age Psychiatry/Geriatrician where available (avoid in those with Lewy Body Dementia or Parkinson’s Disease). Consider use of Quetiapine and Olanzapine as 2nd and 3rd line alternatives respectively. Avoid haloperidol use in this age group because of risk of parkinsonism and cardiac arrhythmias.
3. If oral therapies fail consider IM or IV sedation. This decision must be made by a senior doctor (i.e. Middle Grade Registrar/Consultant) and following discussion with Old Age Psychiatry/Geriatrician where available. As with any sedation this should be administered in an area where the patient can be properly monitored and where airway support is available (Resuscitation Room in the ED).

4AT
Validated rapid assessment tool for delirium/cognitive impairment screening at first contact with patient: incorporates 4AT

1. Alertness
   Normal (fully alert, but not agitated, throughout assessment) 0
   Mild sleepiness for <10 seconds after waking, then normal 0
   Clearly abnormal 4

2. AMT4 (4-item Abbreviated Mental Test)
   Age, Date of Birth, Place (name of hospital/building). Current Year
   No mistakes 0
   1 mistake 1
   2 mistakes/untestable 2

3. Attention
   Months of the year backward
   Achieves 7 months or more correctly 0
   Starts but scores <7 months / refuses to start 1
   Unstable (cannot start because unwell, drowsy, inattentive) 2

4. Acute Change or fluctuating symptoms?
   NO 0
   YES 2

Total

Initial Check list for Potential Causes of Delirium

- Check for hypoxia/hypotension/hypoglycaemia
- Check if patient has pain
- Check for visual or hearing impairment
- Check for urinary retention (consider ultrasound)
- Check for constipation
- Check for recent admission or withdrawal of medication, including patches - especially benzodiazepines or opiates
- Check for major electrolyte disturbance
- Check for an infection - e.g. UTI LRTI
- Screening Tool (links overleaf)
- Consider if alcohol withdrawal syndrome is possible
- Check for pre-existing cognitive impairment or prior history of delirium
- Check for history of depression

Further work up by admitting team as indicated

Pathways cannot cover all clinical scenarios. Ultimate responsibility for the interpretation and application of these guidelines, the use of current information and a patient’s overall care and wellbeing resides with the treating clinician.
Contact Information:
For further information, please contact the National Clinical Programme for Older People, Programme Manager, Helen Whitty E-mail: helenwhitty@rcpi.ie

Web Link: http://www.hse.ie/eng/about/Who/clinical/natcllinprog/olderpeopleprogramme