Enhanced Community Care

# Kildare & West Wicklow ICPOP pilot study to provide Early Supported Discharge to older adults in Kildare & West Wicklow

## BACKROUND

In the absence of clinical governance from a Consultant Physician in Geriatric medicine, KWWICPOP team developed an altered pathway in collaboration with acute and rehabilitation services within Dublin South, Kildare West Wicklow Community Healthcare. The Kildare West Wicklow ICPOP Early Supported Discharge pilot commenced in October 2022. Older people with complex needs have been shown to have higher than average lengths of stay (ICPOP, 2017).

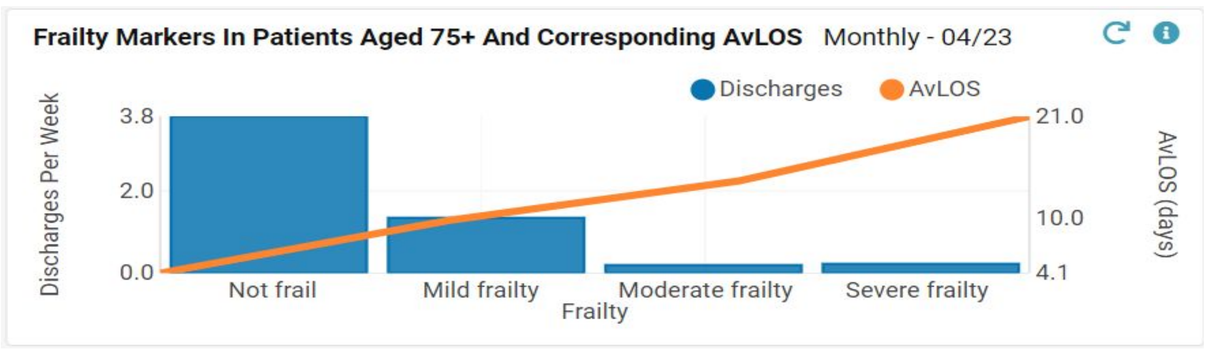


Figure 1: HSE Older Persons Dashboard 2023

## OVERVIEW

133 referrals in the first 8 months of this pilot with:

- 66% from inpatient wards (Early Supported Discharge and reduced hospital bed days).
- 22.5% from Naas General Hospital Frailty Intervention Team (admission avoidance)
- 11.5% other sources (Peamount, TUH, SJH, GP & others)

**Interdisciplinary Team input**

96% of patients received Physiotherapy

98% Occupational Therapy

45% Dietitian* (0.5 WTE)

57% CNMII Clinical Case Manager input

**Keyworker**

Each client had an average of:

- 2 direct (face-to face)
- 12 indirect (telephone contact/contacts with community partners) contacts per patient

## OBJECTIVES

KWW ICPOP CST is an Interdisciplinary team whose aims, in line with Sláintecare, are to:

- Provide timely planned coordinated care via a therapy at home model
- Minimise acute hospital admissions
- Facilitate early supported discharge
- Augment the link between acute and community services
- Provide Early Supported Discharge for older adults (> 65years) in acute or community care who would benefit from receiving multidisciplinary coordinated rehabilitation, (>2 disciplines currently employed on KWW ICPOP) in the home

## FUTURE DEVELOPMENTS

- Athy and Naas community based clinics are now operational
- 32% of KWW ICPOP clients have been reviewed in community based clinics
- Establishing future clinical sites throughout Kildare & West Wicklow
- Accepting GP referrals
- Ongoing recruitment and retention of staff

## CASE STUDY INTERVENTION: MARY

- 74-year-old lady with frequent admissions to NGH with general malaise, reduced appetite, RSV positive
- **Medical history:** HTN, high cholesterol, COPD
- **Social history:** Widow x 6 years. Lives alone with her cat. Does not drive. No formal supports in place, informally supported by her sister-in-law and nephew. Neighbours reporting house in poor repair and Mary struggling to cope.

## CLIENTS JOURNEY

**MDT**
- Case worker present the results of CGA at MDT and generates internal referrals to other team members as needed

**Onward referrals as necessary**
- If referrals are required to other services not currently in post, referrals are sent to primary care services. Clients may also be referred to external services

**Discipline specific assessment**
- Each discipline carries out their own individual assessment and treatment, and clients are discussed at MDT at regular intervals to ensure care is coordinated

**Discharge**
- A discharge summary is prepared by each discipline involved in the clients care. The compiled discharge summary is sent to the clients GP and local primary care centre.

**Feedback**
- All clients and their families are given a feedback form to complete at the end of their episode of care

## INTERVENTIONS

**Physio**
- Review of mobility and balance.
- Provision of monitored home exercise programme addressing deficits
- Outdoor mobility assessed
- Provision of suitable mobility aid to facilitate safe and easy access to the community
- Falls prevention education provided

**Occupational Therapy**
- Environmental assessment and education on falls hazards and home set up
- Provision of adaptive equipment to reduce clients risk of falls and maximise safety (Orthopaedic chair, CTS+F, bath board, second stair rail and rail at front door)
- Education on transfer techniques
- Bed in poor repair- Linked with Alone& S.V.P. to provide a new bed

**Dietitian**
- Malnourished on assessment- advice on diet provided
- Arranged meals on wheels service
- Liaised with GP re need for prescription for Oral Nutritional Supplements

**Clinical Case Manager / CNM II**
- Skin assessment and liaison with GP for medicated creams
- Education on medication compliance

## MARY'S FEEDBACK


*"Ye did everything under the sun for me, ye have me spoilt"*

*"You're magic people"*

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Kildare West Wicklow ICPOP Team.

Reference: HSE/ICPOP(2017) Making a start in Integrated Care for Older Persons guide