"WE COULDN'T HAVE DONE IT WITHOUT YOU", A SERVICE-USER'S PERSPECTIVE

Enhanced Community Care

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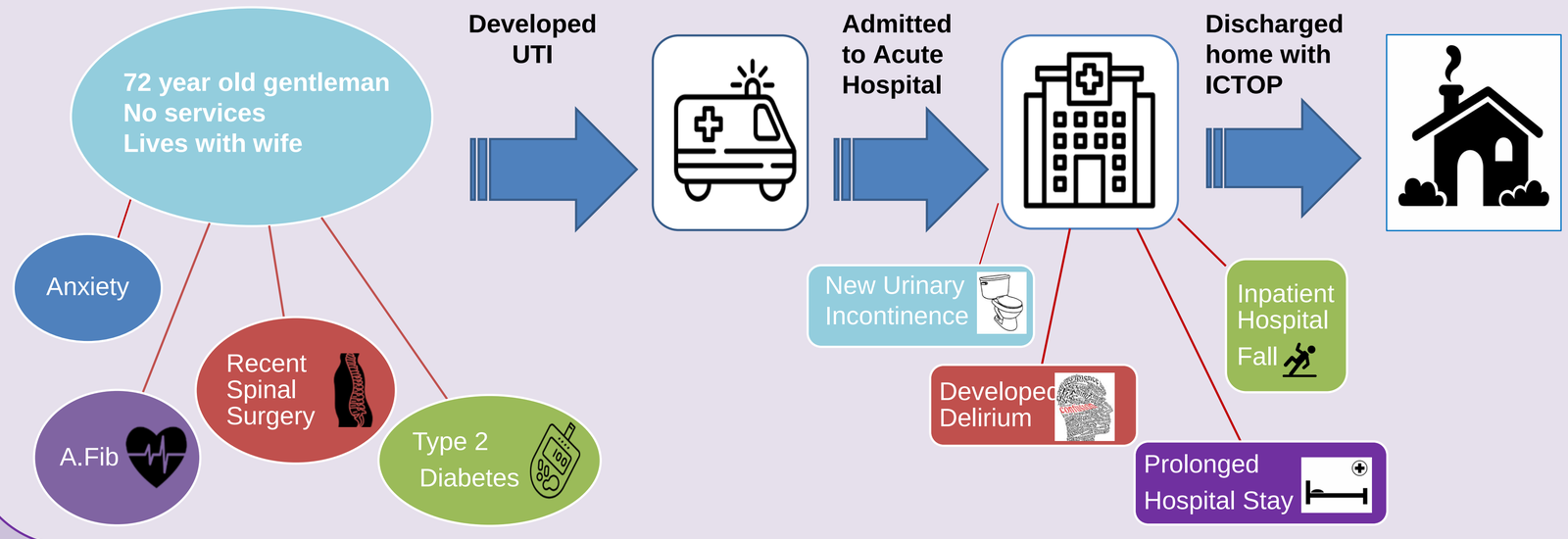
INTRODUCTION

Key principles in the Enhanced Community Care Programme are supporting the transition from hospital to home and supporting care management at a local level (HSE,2023). The following is a case study of a service-user who was referred to the Integrated Care Team of the Older Person (ICTOP) service. The purpose of this referral was to aid his transition from the acute setting to home by helping to address his resolving delirium and underling cognitive concerns, mobility issues, incontinence & safety concerns. ICTOP supported both the service-user and his family during this transition, while managing his medical and functional issues at home, preventing hospital readmission. On initial assessment a Comprehensive Geriatric Assessment (CGA) was completed. It was identified he would require input from the following team members: Clinical Nurse Specialist, Physiotherapist, Occupational Therapist and Therapy assistant, all under the clinical governance of the Consultant Geriatrician..

BACKGROUND



AIMS AND OBJECTIVES

- To provide patient-centred care in the patient's own home
- To promote independence and improve patient outcome measures
- To provide education to service-user and his wife so they can take an active role in managing their own health
- To prevent hospital re-admission

ICTOP INTERVENTIONS




- **Education**: of service-user & his wife about delirium recognition and management, medication management → avoided another admission thanks to early UTI treatment with Geriatrician input
- **Sign-posting**: of appointments, co-ordination between GP, PHN, Urologist and Geriatrician → integration of care and shared purpose; enhanced healthcare navigation
- **ADL Rehab**: strategies for managing personal care and domestic tasks → increase patient's independence and thus reduced his wife's carer burn-out
- **Cognition:** MoCA: 20/30, Cognitive health strategies & Cognitive-Communication programme completed. → increased independent use of cognitive compensatory strategies and increased cognitive stimulation within routine.
- **Falls Prevention:** supported in organising grab rails and pendant alarm → reducing risk of and mitigating adverse outcomes from future falls
- **Mobility:** strength and balance exercise programme. New 4 wheel rollator provided → improved Timed up and Go (TUG). Significant reduction in Fear of Falling.

SERVICE-USER QUOTES

"Only for you, I would definitely have ended up back in hospital"

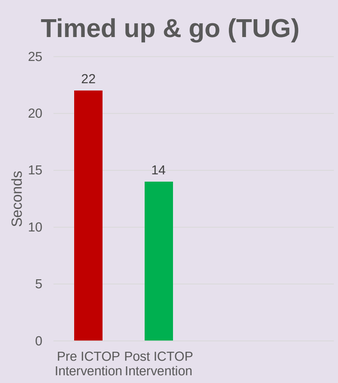
"We'll miss ye when your finished"

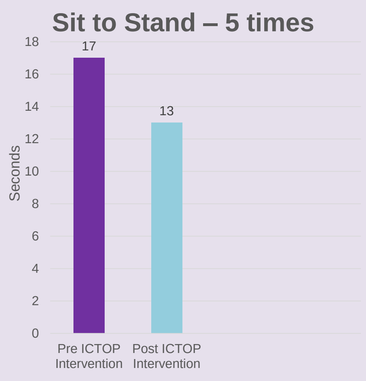
"We felt really supported, it's an amazing service"

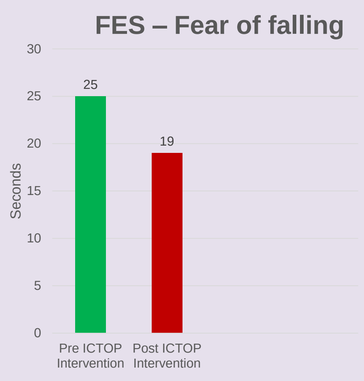
"I don't know what we would have done without ye"

OUTCOMES

- This service-user made significant functional gains. This resulted in a reduction in carer burden.
- Pre-ICTOP input, service-user had 3 hospital admissions in the preceding 7 months. 12 months post-input he has had no hospital admissions or ED presentations.
- Clinical Frailty Scale (CSF) scoring improved from a 6 (Moderately Frail) to a 5 (Mildly Frail).
- The following results demonstrates improvements in overall function, mobility, strength and fear of falling.







- Timed up and go 36% reduction in falls risk
- The Sit to Stand-5 times showed increased strength
- FES went from Moderate Fear of falling to a Low Fear of Falling

CONCLUSION

The measurable outcomes and the service user's own words demonstrates first-hand his perspective on how ICTOP's input supported him and his family.

Provision of a holistic and integrated service within the patient's own home enabled him and his family to improve his health and his wellbeing where he most wanted to be "at home".

Reference: HSE(2023) Enhanced Community Care. Available at: http://www.hse.ie(accessed 31 July 2023).