Integrated Care Team for Older Persons, Dublin North West

SUPPORTING COMPLEX SEVERELY FRAIL ADULTS AT HOME

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Introduction

In September 2022, the Integrated Care Team for Older Persons (ICTOP) in Dublin North West (DNW) became the first ICPOP team nationally to be fully staffed. The team covers four community health networks and provides an interdisciplinary assessment and intervention for people living in the community. The team aims to respond within 24-48 hours to referrals and on average cases are open for 6-8 weeks. The DNW region has a population of over 164,000 people of whom 18,500 are aged 65 or over.

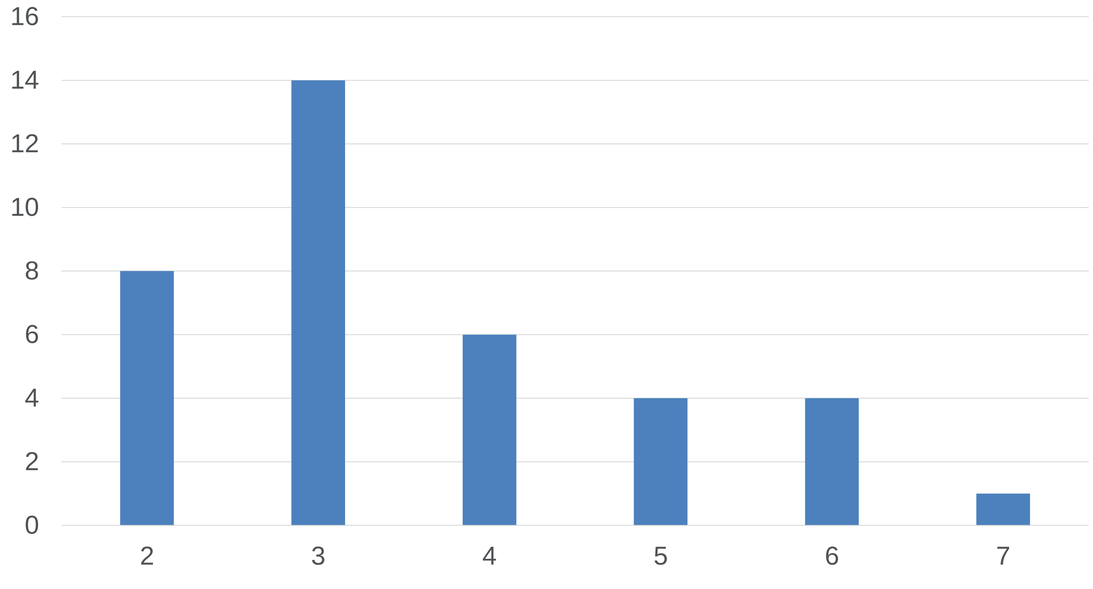
Method

The team consists of 12.5 WTE including Senior Physiotherapy, OT, SLT, MSW, Dietician, Nursing and Medical. The team also has the support of two therapy assistants and two administrators. The team work in a 100% domiciliary environment.

Each referral has a comprehensive geriatric assessment completed and a care plan is created in partnership with the service user which identifies interventional goals. Weekly MDMs led by the consultant geriatrician ensures efficient case management and timely discharges from the service.

Average number of MDT clinicians from the team involved with each referral is 3 with a range from 2 to 7.

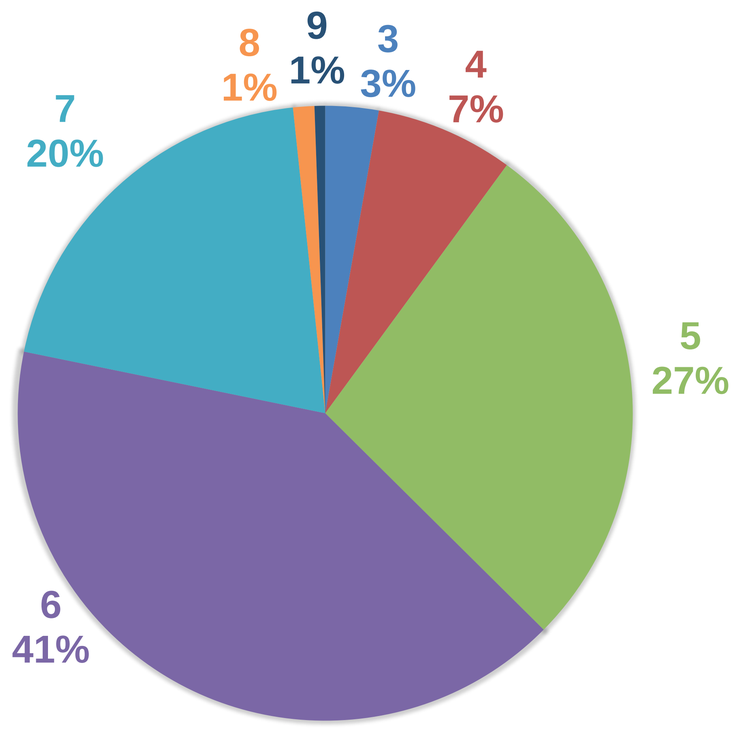
Figure 1: No. of MDT interventions per referral



Results

From September 2022 to July 2023 a total of 216 referrals were received, of these 39 (18%) patients had a CFS or 7 or more.

Figure 2: CFS score for all referrals Sep 2022 to July 2023



28 (13%) referrals involved interagency work with colleagues from Community Palliative Care, Psychiatry of old Age, Primary Care Teams, Public Health, Community Gardaí, ALONE, Sage, HSE Home support Teams, Inpatient rehab in Cappagh and St Mary's & Holly Day Hospital. 34 (87%) of referrals were supported to remain at home. 9 Intensive Homecare Packages supported those with dementia and high care needs to facilitate this.

Figure 3: Patient outcomes Sep 2022 to July 2023

Total referrals CFA > 7	Remains At Home	RIP	Transitioned to LTC
39	34	1	4

Conclusion

The involvement of the ICPOP team in DNW with these severely frail complex patients was instrumental in keeping them at home and avoiding unplanned admission into an acute service or premature nursing home care. Ongoing development of community based pathways to access supports via statutory and voluntary bodies and avoiding hospitalisation will support many others to remain at home with better health outcomes.