Enhanced Community Care

DEVELOPMENT OF AN ULTRA-RURAL ICTOP SERVICE: ONE YEAR ON

Dara Dardis (Senior Occupational Therapist), Maria Armstrong (Senior Physiotherapist) & Laura Maguire (Clinical Nurse Specialist)
Integrated Care Team for Older Persons (ICTOP) Sligo Leitrim.
Email: dara.dardis@hse.ie

Introduction

The avoidance of unnecessary admissions and supporting safe hospital discharges are key principles in the Enhanced Community Care Programme in Ireland. The National Clinical Programme for Older Persons aims to promote high quality and holistic care, provided in the right place at the right time for the older adult. In simple terms, this means bringing care closer to where the older person lives, and some cases, into their homes. The national development of Integrated Care Teams for Older Persons based in local communities has been a key factor in provision of care aimed at supporting the older person's safety and independence to enable them to live in their own home for as long as possible. One such team was developed in County Leitrim, which, according to a 2020 TILDA report (O'Halloran et al), has the highest prevalence of frailty in the country (29.76% in 55+ and 48.36% in 70+).

Methodology

The team was established in March 2022 and comprised of the following MDT members: Consultant Geriatrician, Clinical Nurse Specialist (Gerontology) Clinical Nurse Specialist (Mental Health), Occupational Therapist, Physiotherapist & Therapy Assistant. The team also had input from a Case Manager, Dementia Clinical Nurse Specialist and Advanced Nurse Practitioner from a linked team in a neighbouring county.

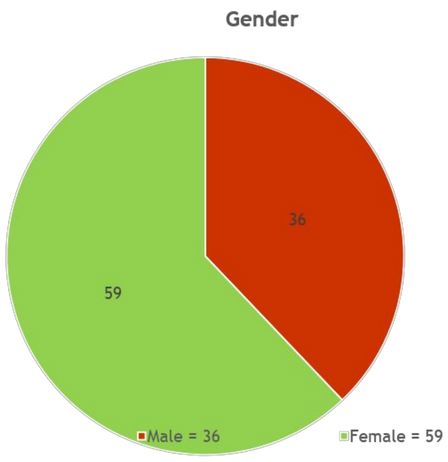
As a newly established service, quantitative data and subjective feedback was gathered from April 2022 to March 2023 from 95 patients to identify:

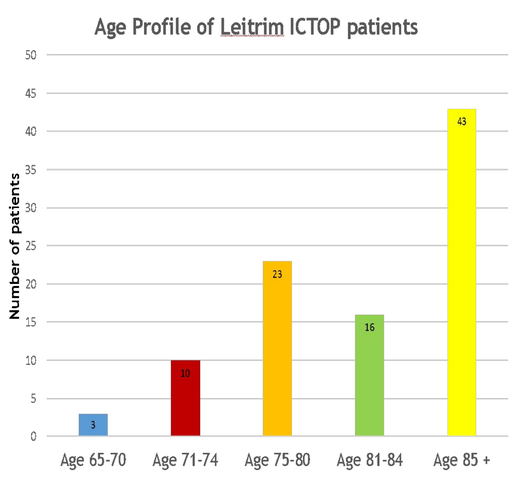
1) Referral demographic trends
2) Frailty levels and MDT needs of service-users
3) a) Service-user reported outcomes b) objective outcomes.

Additionally, we hope to use this information to identify future-planning needs for service development.

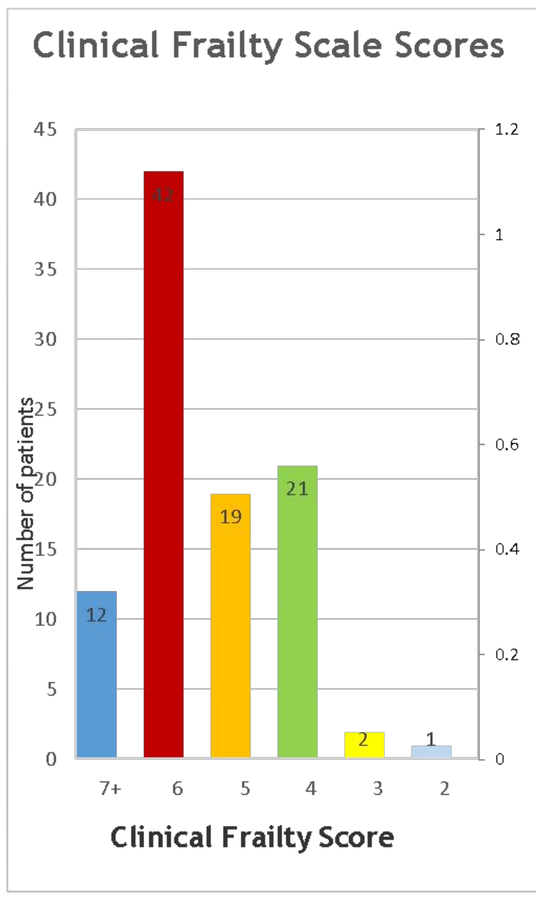
Results

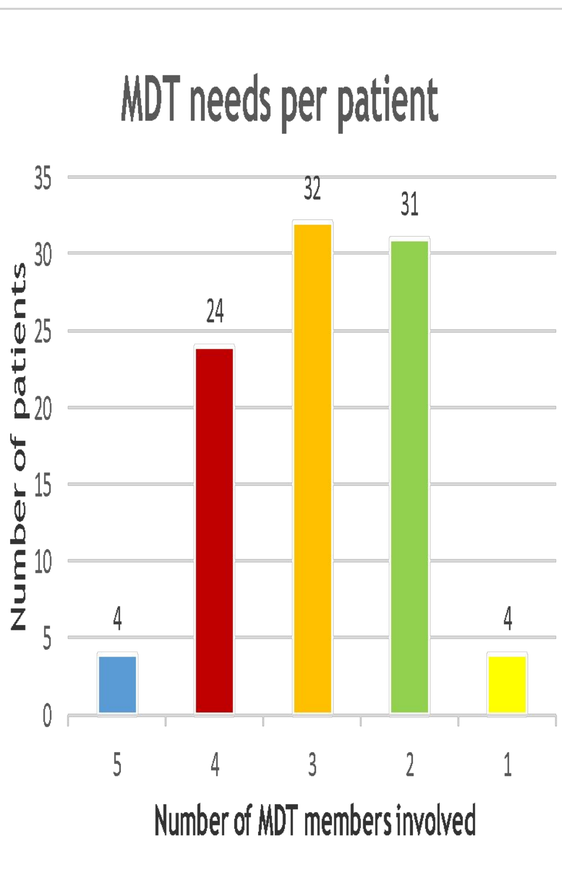
1.Referral demographic trends





2. Frailty levels and MDT needs of service-users





3. Outcomes

a) Service-user reported outcomes

"We're delighted to have this service coming to our own home" (service-user)

"Your team has come at the right time and pulled everything together" (family member)

"Thanks for getting me on the road to recovery" (service user)

b) Service-user objective outcomes

- Timed Up and Go tests showed an average improvement of 10 seconds with a 6 week programme , resulting in 40% improvement. This represents an improvement of 40 % in function with correlates to balance, mobility and fall risk.
- 5 times Sit to Stand test also demonstrated a clinically important difference of 9 seconds average improvement with 6 week programme, resulting in 37.5% reduction in falls risk and increased functional lower limb strength.
- Cognitive assessment and intervention was required with 64% of service-users. Of this 64%, 48% had newly identified cognitive concern and were referred for either cognitive monitoring via their GP or Geriatrician follow-up. The remaining 16% of this cohort had an established dementia diagnosis and were generally under regular follow-up.
- 55% of service-users had identified needs which required onward referrals to additional health & social care teams, to support their well-being at home.

Conclusion

- A high proportion of service-users had a CFS of 6/7, were in the 85yo+ bracket and approximately 50% required either onward referral due to cognitive concern or to additional health and social care services. Over 95% required 2 or more MDT members input. This suggests that the caseload presented with significant complexities in relation to frailty and social care needs. The team developed extensive links with local community services to support the longer-term needs of service-users post-discharge from our service.
- One year post commencement of service, it has been identified that further MDT specialist involvement will be beneficial given service-user complexity e.g. Dietician, Social Worker, SLT.
- Results and patient feedback are favourable to suggest the Integrated Care Team has a strong role in supporting service-users well-being at home and lends itself to supporting avoidance of unnecessary hospital admissions.

References

O'Halloran, A., McGarrigle, C., Scarlett, S., Roe, L., Romero-Ortuno, R. & Kenny, R.A. (2020) 'TILDA Report on Population Estimates of Physical Frailty in Ireland to Inform Demographics for Over 50s in Ireland during the COVID-19 Pandemic' (TILDA). Available at: Report_Covid19Frailty.pdf (tcd.ie) (accessed on 19 September 2022).