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Safer Transitions: Optimising Care and Function from Hospital to Home

Abstract

Elderly patients living with frailty have complex and distinct needs. For many, being admitted to hospital has an adverse affect on their outcomes. Prolonged hospital admission is evidenced to lead to decreased mobility and function, negative cognitive change including delirium, increased mortality and increased likelihood of institutionalisation.

The introduction of the Frailty Intervention Therapy Team (FITT) in the Emergency Department (ED), Beaumont Hospital in 2015 was a key component in developing our understanding of effective ways to manage this patient group, preventing admission wherever possible. On a weekly basis, up to 10 patients were being identified as potentially suitable for home discharge from the ED. However, this was contingent on the availability of immediate, short-term therapy to facilitate a return to baseline and/or safe functioning in their home environment. It was in this context that the Occupational Therapy (OT) Services in Beaumont Hospital and Dublin North, who had a long history of collaborative working, embarked on a partnership to test an Integrated Care Service model for frail patients admitted to Beaumont Hospital. At the time, only OT staffing (1WTE) could be dedicated to the service. However, the OT had access to community OT, GP, PHN, some Physiotherapy and Geriatrician review (via Day Hospital) where required.

This Integrated Care Service, which commenced in October, 2016, aimed to meet the acute and often complex needs of this patient group by firstly, avoiding admission and facilitating safe discharges home. Discharge could then be supported through early intervention (rehabilitation, case management), followed by handover to primary care teams as indicated. To date, 43 patients have participated in this service. The majority were referred from the ED but referrals have also been accepted from the Virtual Ward (CHO9 Service aimed at admission avoidance) and Beaumont Hospital in-patient wards.

Remarkably, 50% of patients discharged home have been between 80 and 89 years old. Interestingly, 43% of the total number of patients live alone and 50% are living without formal home care hours. The primary reason for hospital presentation was falls (51% of cases), with 18% sustaining a fracture. On assessment, 44% of patients were identified to have a cognitive impairment.

Results have been most encouraging. Firstly, all patients were safely discharged and maintained at home with the exception of three patients who required readmission within 30 days for medical reasons. This outcome is significant on two levels; it represents a truly client-centred response to care since all patients indicated their preference was to return home once the necessary support could be provided and furthermore, over 600 bed days have been saved in this brief test period alone. Therapeutic interventions led to significant functional gains with 86% experiencing improved mobility/reduced risk of falls post intervention. In addition, two-thirds made functional gains (as reported using the Functional Independence Measure) while the remaining 33% of patients were successfully maintained at their functional level.

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Patients received, on average, 3.5 intervention sessions, equating to seven hours of treatment time which included direct/indirect interventions and travel time. Notably, though, only 10% patients required follow-up from primary care services on discharge and in these cases, a streamlined pathway had been established.

This model undoubtedly provides a client-centred, cost effective means to safely transition frail patients home and will be further enhanced with the development of six Integrated Care Teams nationally in 2017.

Location

Ireland

Year

2017

Related Integrated Care keywords

- SERVICE, FUNCTION AND CARE INTEGRATION / COORDINATION – TRANSITIONS

Pervasiveness

Large scale in a region

Status

Operational

Links

https://www.ijic.org/articles/abstract/10.5334/ijic.3912/