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CONFERENCE ABSTRACT

Frailty Intervention Therapy Team (FITT): A Step in the Right Direction - Integration of Early Interdisciplinary Assessment in the Emergency Department.

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Introduction: Beaumont Hospital is committed to delivering on the objectives of the National Clinical Programme for Older People (NCPOP) and the Integrated Care Programme for Older Persons. The clinical needs of older people presenting to the Emergency Department (ED) are substantially different to those of younger adults. Many older people present with acute or sub-acute illnesses, which may be accompanied by functional and/or cognitive deterioration. Additionally, these patients often have complex social care needs. Evidence confirms that Emergency Department overcrowding is associated with increased mortality, increased length of stay, patient harm and reduced staff morale and therefore, hospital admissions for frail older people should be avoiding where at all possible. Prior to September, 2015, Beaumont Hospital (BH) provided an on-call Health and Social Care Professions (HSCP) service to the ED which focused only on facilitating patient discharge. The team comprised Occupational Therapy (OT), Physiotherapy (PT) and Medical Social Work (MSW). Speech & Language Therapy (SLT) was available for patients who had been admitted and were assessed in the ED. Referrals for this service were triggered by an ED doctor or Clinical Nurse Manager (CNM). However, during periods of increased patient presentations, referral rates were found to reduce significantly. This was explained by the competing pressures felt amongst ED colleagues in these times with the result that HSCP referral was not considered. At that time, there was no HSCP service based in the ED to initiate assessment for those patients deemed suitable for admission. It was in this context that BH, in late 2015, developed the Frail Intervention Therapy Team (FITT) to respond to the needs of all frail patients attending ED.

Theory and Methods: The FIT Team comprises PT, OT, MSW as well as Speech and Language Therapy, Dietetics and Pharmacy. The vision for the FITT service is to foster a culture of 'every hour counts' for frail elderly patients and to this end, the team aims to:

Identify 100% of frail patients, over the age of 75 years, who present to the ED during core hours

Provide rapid access and comprehensive multidisciplinary team (MDT) assessment to all patients identified as frail

The development of this model for service delivery was firmly underpinned by quality improvement methodology. Interactive HSCP planning workshops guided the process while the model for improvement (PDSA cycles) was key to:

A) fostering frontline ownership

B) critiquing practice and

c) developing effective care pathways and supporting processes.

Delivering on the above aims required a very different approach to care. Now, treatment begins at the front door with HSCPs initiating the frailty assessment without awaiting referral from other disciplines. The "Think FRAILTY" assessment tool is used to identify patients with one or more frailty syndromes – immobility, delirium/dementia, poly-pharmacy, incontinence or end-of-life care. When a patient is identified as frail, his/her specific care needs are established with early identification of the appropriate care pathway i.e. admission or supported discharge with immediate referral to other MDT services as indicated.

For patients deemed to require an admission, rehabilitation commences on the first day with the result that optimum recovery opportunities are provided. Additionally, harm associated with prolonged ED length of stay and unnecessary deconditioning is avoided.

Where patients are recommended for discharge, a rapid access, intensive rehabilitation service is provided, consistent with the well evidenced 'Home First' ethos. This outreach model has been developed in partnership with community colleagues in North Dublin, ensuring an integrated response for frail patients.

Results: Since September, 2015, over 7,500 patients have been screened for frailty. Of these, 75% were deemed as frail and referred on to MDT colleagues as appropriate, significantly increasing activity from the front door. Comparing year-to-date outcomes from 2015 and 2016, there has been an 11.6% (N=614) increase in the number of patients over 75 years presenting to the ED. Of those screened for frailty, 83% required HSCP intervention and the average age of this patient group was 84 years (range 75 to 97 years).

Encouragingly, 50% of these patients were discharged in less than 9 hours between January and August, 2016 as compared with 32% in the same period in 2015. For those being admitted, 18.3 % were admitted in less than 9 hours between January and August, 2016 compared with 11% in 2015. Overall, there has been a notable decrease in length of stay with 25% of all admitted patients, over 75 years, being discharged by day three and 50% discharged within seven days.

A 2016 retrospective audit of 224 ED presentations, aged 75 years and over who were screened for frailty, confirmed that 75% were frail, 35% lived alone, 52% had no formal supports, 17% had no formal or informal supports, 7% were nursing home residents, and 8% of those who lived with family were the sole carer of a dependant family member. These findings point to the fact that regularly, frail patients presenting to the ED were previously

functioning at a high level of independence and could be sustained at home with access to the right supports and intervention.

Conclusion and Discussion: In line with best available evidence and practice, the FIT Team undertook to provide early intervention for frail adults with the intention of ensuring they receive the right care, at the right time, in the right place.

Early results are extremely positive and the team continues to work closely with the Clinical Strategy and Programmes Directorate to help inform the development of frail older persons' services nationally.

Keywords: interdisciplinary; frailty; emergency department; early assessment