Integrating a Frail Elderly Assessment Team into a Mayo Community Virtual Ward.

Presented by: Victoria McGuinness, Frail Elderly Assessment Team Social Worker, Mayo University Hospital. 
Marie Alexander: Director of Nursing, Ballina District Hospital, Co.Mayo
The Vision

• Integrating care needs of the Frail Elderly living in Mayo.
• Supporting older people in their decision for Discharge Home.
• Early intervention and Assessment to improve patient flow within Mayo University Hospital.
• Reduce Hospital re-admission rates.
• Development of a Frail Elderly Pathway to ensure the safest and quality based care for our elderly patients.
THE FRAIL ELDERLY ASSESSMENT TEAM
Mayo University Hospital

Mandy Brady/ Clare Green (Clinical Pharmacists)
Victoria Mc Guinness (Medical Social Worker)
Mairead O’ Boyle (Clinical Nurse Manager)
Sarah Ronayne (Occupational Therapist)
Simon Rowan (Physiotherapist)
MAYO ELDERLY POPULATION

Mayo has a population of 130,638 residents.
19,539 are over the age of 65 years
Approx 15% over age of 65 years

Source: Central Statistics Office 2011

Frail Elderly Assessment Team
Current Criteria

Patient s > 70 years presenting with:
• Falls (episode of fall in last 3 months).
• Immobility (“off the feet”/deterioration in mobility).
• Cognitive impairment (new onset/deterioration).
• Polypharmacy.
• Incontinence.
Screening Tools

Standardised Screening Tools

- **PRISMA-7** (Raich et al, 2007)
  - 7 point questionnaire
  - Score of 3+ Identify frailty
- **Mini-Cog** (Borson et al, 2000)
  - Recall-distractor-recall test
  - Identify cognitive impairment
- **4 Metre Gait Test** (Abellan van Kan et al, 2009)
  - Mobility assessment timed over 4 meters
  - >5 seconds indicates frailty

Non-Standardised Screening Tools

- Psycho-social history
- Establish baseline and identify changes in / concerns re:
  - Functional/mobility status
  - Care needs
  - Home environment
What we do:

**Early Identification**
- Identify presence of Frailty Syndrome(s)
- Measure frailty syndromes using PRISMA-7, Mini-Cog, 4 Meter Gait Speed Test

**MDT Assessment**
- Co-ordinated MDT assessment to include: Pharmacy, OT, PT, MSW and Nursing
- Early information gathering/sharing with relevant PCCC team members

**Patient-centred Planning**
- Act as patients advocate, this involves communicating, negotiating and representing patients’ values and decisions in collaboration with MDT.
- Early referral and summary of recommendations to relevant inpatient / PCCC services
- Co-ordination of acute and primary care services for effective /safe discharge plan

Key Worker Role – patient is central
An Overview : Phase 1

<table>
<thead>
<tr>
<th>December 2015 – October 2016</th>
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<tbody>
<tr>
<td><strong>Total number of patients assessed by FEAT during pilot (10 months)</strong></td>
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<tr>
<td><strong>% Patients identified as Frail</strong></td>
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<tr>
<td><strong>% FEAT patients assessed within 24 hours of acute inpatient admission (weekends/leave)</strong></td>
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<tr>
<td><strong>Reduction in avLOS for patients seen by FEAT</strong></td>
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<tr>
<td><strong>% patients discharged home</strong></td>
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<td><strong>Re-admission rate</strong></td>
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### An Overview: Phase 2

<table>
<thead>
<tr>
<th><strong>Total patients seen by FEAT since October 2016</strong></th>
<th>250 patients (48 % of over 70s admitted to MUH)</th>
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<tbody>
<tr>
<td>avLOS of FEAT &gt; 70s</td>
<td>6.1 days</td>
</tr>
<tr>
<td>avLOS MUH &gt; 70s</td>
<td>8.5 days</td>
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<tr>
<td><strong>Discharge outcomes for FEAT patients</strong></td>
<td></td>
</tr>
<tr>
<td>• % patients discharged home</td>
<td>69%</td>
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<tr>
<td>• % patients discharged convalescence</td>
<td>28%</td>
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<tr>
<td>• % other (other hosp/RIP)</td>
<td>3%</td>
</tr>
<tr>
<td><strong>Identified as Frail (Prisma &gt;3)</strong></td>
<td>82%</td>
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<tr>
<td><strong>Identified Non-Frail (Prisma 0-2)</strong></td>
<td>18%</td>
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<td>Average Prisma</td>
<td>5</td>
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<tr>
<td>Average Barthel Index</td>
<td>12 (moderate physical impairment)</td>
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Our Findings

Prevalence of Frailty Syndromes on Admission

- Polypharmacy: 53%
- Falls: 32%
- Immobility: 21%
- Delirium/cognitive deterioration: 20%
- Incontinence: 6%

% patients (n=614)
OUTCOMES FOR ADMITTED PATIENTS

Frail Elderly patients identified as suitable for admission to Community Virtual Ward

avLOS: 1 day less per patient
What is a virtual ward?

“method of providing care to people in the community who are most vulnerable to repeated hospital re-admissions”

Lewis et al (2010)
MAYO COMMUNITY VIRTUAL WARD TEAM

Marie Alexander - Director of Nursing Ballina District Hospital (Virtual Ward Facilitator)
Helen Browne - Director of Public Health Nursing Mayo.
Paula McGreal - Nursing Discharge Manager, Mayo University Hospital
Mairead O’Boyle - CNM2 Frail Elderly Assessment Team, Mayo University Hospital. (Virtual Ward System Coordinator)
Mary O’Malley - Assistant Director of Public Health Nursing Mayo

Virtual Ward Governance Group established 2015
Mayo Community Virtual Ward

Background

• Established in 2013- Funding from the Nursing and Midwifery Practice Development Unit.

• Integrate health and social care by offering multi-disciplinary case management to the frail elderly.

• Intervention used to support patients in the community who are a high risk for unplanned admission.

• Patients remain at home & receive multi-disciplinary approach to address individual needs across health and social care.
Aim:

• To deliver innovative and co-ordinated care to the Frail elderly living in the community.

• To streamline and co-ordinate care for elderly patients who are at risk of hospital re-admission.

• to improve continuity and quality of care across providers and ensure resources in the community are used effectively by targeting those most at risk of re-admission.

• 2013- 1 year pilot ( Ballina area only)
• 2014 – present- extended to Mayo area
The predictive model uses a scoring system known as LACE tool and evaluates risk based on:

- Length of stay
- Acuity of admission
- Co-Morbidities
- Emergency Department Visits

*LACE Index Scoring Tool for Risk Assessment of hospital re-admissions*

*Ottowa Hospital Research Institute, (2006)*
Identify Elderly Patients who are at risk of unplanned readmissions due to:
• Complex issues requiring more structured integrated care.
• Social concerns
• Risk stratifying using LACE tool
>10=admission
PATHWAY CONTINUED....ACTION PLAN

1. Patient are admitted to Community virtual ward for MDT discussion at weekly Teleconference.
2. Relevant stakeholders are alerted via email of pending teleconference and attendance required.
3. Patients are discussed at scheduled time.
4. Care plan and action plan agreed with achievable goals for individual patients.
5. Minutes are taken by virtual ward facilitator and emailed to relevant stakeholders to ensure continuity of care.
6. Decision is made to discharge patient once goal is achieved or continue MDT input on virtual ward if required.
CASE EXAMPLE

87 year old female admitted to Mayo University Hospital in October 2015. Discharged in August 2016

**History:**
LOS of 322 days on acute medical ward in MUH following:
- a fall, pubic rami
- development of grade 4 pressure sore at home
- diagnosis of osteomyelitis on sacrum.
- Treated for regular UTIs

**Hospital interventions:**
- IVABs, pressure area care, plastics in UCHG, MDT input.

Patient discharged home and admitted into Community Virtual ward for weekly MDT discussion via teleconference
Case Discussed by Community Virtual Ward Team on Teleconference

INTEGRATED CARE APPROACH

- Patient
- Ward CNM
- Nursing Discharge Manager
- PHN
- PHN Liaison
- Virtual Ward facilitator
- Frail Elderly Team
- Home Help Department
- Director of Public Health Nursing
- Community Dietitian
- Community OT
- Hospital OT
- Hospital physio
- Hospital Dietitian
Example of Issues identified on Virtual Ward Teleconference:

- Equipment - mattress had left MUH before patient arrived home, however a sensor part was missing.
- Patient developed loose stool, decreased appetite & weightloss.

Interventions put in place - samples sent to lab, GP contacted to take bloods, c-diff positive - commenced OAB. Reviewed by community dietitian.

Outcome:
Patient remained on the CVW for six teleconferences
Patient has not presented to acute setting since discharged August 2016.
Through continuous integrated case load management by the Virtual Ward Team this elderly patient has remained at home and is coping well and has avoided re-admission to Mayo University Hospital.
BENEFITS

• The Mayo Community Virtual Ward is key to patients safety and provides a valuable link between primary care and community.
• Patients and families report that they value the feeling of safety that comes from the community virtual ward experience.
• Staff from PCCC in Mayo and the acute hospital have also reported to finding it rewarding working as part of the Virtual Ward Team as it offers the opportunity to share problems and find solutions with colleagues who are caring for the same patient.
THE FUTURE

• Plan to integrate and expand to virtual ward clinics for patients with chronic conditions to prevent re-admission (e.g.) CCF, COPD patients
• Integrate with OPAT services if approved to facilitate early discharges through IVAB treatment at home.
• Application for extension through additional funding.