Urgent Care Needs for Older People

Frailty at the Front Door

Context

In response to the Acute Hospitals Division unscheduled floor model re-design project, the National Working Group for Older People (ICPOP, NCPOP) has drafted the following document to highlight the key areas for consideration, when designing an acute floor model to meet the needs of the older population living with frailty in Ireland.

The project aims to define the key functions of the acute floor, determine how different components relate and operate, to meet the expectations of patients, in a manner that maximises patient flow. Numerous workshops and consultations have commenced with technical partners, GE Healthcare, to scope out key functions and design principles, with initial report due September 2017. This document reflects the changing demographic landscape of the older population living with frailty, and the critical response required from our health care system, to meet the demands associated with this demographic change.

Background

- Community dwelling adult Frailty Prevalence (≥ 75 years) is 11% (Very High Risk) and 21% (High Risk) with a further 36% at risk (TILDA, 2017);
- Older people living with frailty tend to have poorer health outcomes compared to those who are robust or pre-frail;
- Older People living with frailty experience more falls, have more disabilities, use more medications and healthcare services than those who are pre-frail or robust;
- Frailty is associated with increasing age.

Over Arching Principles

The overarching principles that inform design (within the acute floor) are;

- The identification and management of frailty is everyone’s business
- Acute floor staff competencies require staff to be frailty attuned
- Frailty pathways are a core component of patient flow within the acute floor

The operational and clinical management of the frailty pathway includes;

- Timely identification and screening of older people as they present to acute hospitals
- Comprehensive Geriatric Assessment (CGA) initiated and referrals
- Assertive case management to enable them to transition within the acute setting
- Assertive discharge processes with a co-ordinated (integrated) response
Core Principles

In line with the recommendations outlined in the National Clinical Programme for Older People (NCPOP), Specialist Geriatric Services Acute Model of Care (HSE and RCPI, 2012), NCPOP Specialist Geriatric Team Guidance on Comprehensive Geriatric Assessment (HSE and RCPI, 2016), and the Integrated Care Programme for Older Persons (ICPOP) 10 Steps Framework (HSE, 2016), the following core principles will support and drive better outcomes for older people with frailty and urgent care needs;

1. Adopt a whole system perspective, building upon a shared common vision - quality care for older people across the whole patient pathway (acute and community settings);

2. Access to a senior decision maker to identify older people at risk or living with frailty at the earliest possible point in their urgent care journey;

3. Older People at risk or living with frailty should be screened at the front door using an evidence-based assessment tool (for example, PRISMA 7, the Rockwood Clinical Frailty Scale);

4. There is an interdisciplinary team to provide holistic assessment and management of older people (through Comprehensive Geriatric Assessment - CGA);

5. The frailty pathway is embedded in processes in the ED, AMUs and on specialty wards;

6. Out of hours services are identified to support timely effective discharge;

7. Older People at risk or living with frailty should be actively involved in their care and the provider able to demonstrate shared decision-making/patient-centred care;

8. Older People at risk or living with frailty should be routinely asked what is most important to them and their responses clearly documented (e.g. NCPOP/HSE QID “What Matters to You” initiative);

9. Continual collaborative work with integrated care teams, evolving governance groups and networks to implement integrated pathways for older people;

10. Education and training for all health care staff to ensure a “frailty attuned” workforce with the skills and competencies to provide care that meets the need of older people (e.g. NCPOP Frailty Education Programme).

What is Frailty?

The clinical condition of ‘frailty’ is one of the most-challenging consequences of population ageing (Clegg et al., 2013, O’Shea, BGS Blog, 2017). Frailty develops as a consequence of age-related decline in multiple body systems, which results in vulnerability to sudden health status changes triggered by minor stress or events such as an infection or a fall at home. Between a quarter and half of people older than 85 are estimated to be frail, with overall prevalence in people aged 75 and over approximately 9% (Collard et al, 2012). People with frailty have a substantially increased risk of falls, disability, long-term care and death. We also know that frailty is a graded abnormal health state which ranges from the majority who are mildly frail and need supported self-management, through those who are moderately frail and would benefit from interventions
such as case finding/case management, to those who have advanced frailty where anticipatory care planning and end-of-life care may be appropriate interventions (NHS, 2014).

**Identify Older People with Frailty and Urgent Care Needs Early**

Frail patients experience an age related increase in rate of decline in multiple organ systems and as a consequence they are particularly susceptible to the hazards of inpatient hospitalization\(^1\). A relatively minor illness may cause a marked decline in their functional abilities and is often the forerunner to requirement for long term care. Not only does this cause extended length of stay in acute hospitals, it is usually in sharp contrast with the patient’s own wishes. An increasing number of frail older patients are presenting to the emergency department. Emergency department presentations have increased by 16\% between 2013 and 2017. 48\% of those presenting to ED aged over 85 years are admitted. Most of these are admitted medically.

Increasing attention is focused on the decline experience by older people while in hospital and ways to prevent this. International literature on this issue indicates a multifaceted approach is required. First, prevent the admission. Second, where this is not possible, prevent the de-conditioning and loss of independence by involving the interdisciplinary team early in the admission. Third, promote safe early discharge to home or to inpatient rehabilitation where this is required. (BGS, Silver Book (2012), Oliver et al., (2013) and Conroy, Acute Frailty Network (2015).

The organisation of care in hospital can exacerbate the effect of frailty. For example, it has been estimated that each ward move while in hospital will increase the length of stay for a person aged over 75 years by two days\(^2\). This increase in length of stay further compounds the problems with hospitalization in this age group. A Cochrane review by Ellis et al demonstrated that patients have better outcomes when they receive timely comprehensive geriatric assessment (CGA)\(^3\). Furthermore, this benefit is significantly greater when CGA is provided on a specialist geriatric unit. These facts lead to the clear conclusion that there is a need to transfer older patients living with frailty requiring admission directly to a specialist geriatric unit in which interdisciplinary CGA can be rapidly provided (HSE and RCPI, 2016).

**Specialist Geriatric Services Acute Model of Care (2012)**

The NCPOP Specialist Geriatric Service (SGS) Acute Model of Care (HSE & RCPI, 2012) defines high quality care, care pathways and services required to meet the needs of the frail older person living with frailty presenting to hospital. For regular users of acute hospital services, plans that interface with community services need to be in place to meet their needs, improving access to home supports and other resources to enable them to stay well and remain at home if possible. Furthermore, appropriate linkages with community services must be in place early to ensure that appropriate services can be planned and operationalised in a timely manner after the acute phase of illness or intervention.

The core components of the SGS includes specialist inpatient wards, on-site and off-site rehabilitation units and rapid access day hospital services, all of which are integrated with mental health, community and primary care services for older people. The key to delivery of the highest standard of care for older people in the acute setting is through a well-functioning interdisciplinary team.

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2. HSE/Serco Commission on Hospital Care for Frail Older People. November 2014.
The SGS model outlines a number of key recommendations for the establishment of a Specialist Geriatric Service to achieve measurable improvements in outcomes for frail older people living with frailty. The recommendations follow the end to end pathway/patient journey from their home, through primary care, acute care and discharge home (or other). The recommendations fit very well in the context of current planned service reorganisation. We agree in principle with the Worthing hospital UK, Emergency frailty pathway (please refer to appendix one), however, recommend the frailty ward is renamed to the Specialist Geriatric Ward (SGW) to maintain consistency with NCPOP working model.

### Acute Model of Care (2012) Key Recommendations:

<table>
<thead>
<tr>
<th>Pathway stage and reference section</th>
<th>Recommendations</th>
<th>Prompts</th>
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| **Identifying people with frailty in ED/AMU** Section 4.5.3.1 (Page 22) | Each ED/AMU in conjunction with Specialist Geriatric Service will have in place an agreed process for identifying/triaging the older adult. | • Is there a process in place to identify frailty?  
• Who takes the lead on this process? Is it interdisciplinary? |
| **Role of SGS in ED/AMU** Section 4.5.3.2 (Page 23) | The SGS will link with the ED/AMU when an older person is identified as having frailty and requires referral to the SGS for CGA/admission to the SGW | • Has an assessment area been allocated to the older adult with fraility in the ED/AMU?  
• Is there a specific pathway in place for the delivery of acute medical care to the older person with fraility with a clinical lead?  
• Is there a formal SGS pathway that begins in the ED/AMU?  
• Have staff completed the National Frailty Education Programme? |
| **Referral to the SGT** Section 4.5.4 (Page 26) | Each SGS will have defined and agreed criteria with their ED/AMU and community that determines whether an older person should be referred to the SGT | • Is there a dedicated core team?  
• Are there formal, defined and agreed criteria for referral? |
| **Patient referral and Intervention Pathway** Section 4.5.4 (Page 26) | Once referred decisions about the appropriate SGS to meet the patients needs will be made by a senior professional within a specified timeframe | • Does this form part of a formal SGS pathway?  
• Are there specific pathways (e.g. Frailty/Delirium/Falls or others)? |
| **Comprehensive Geriatric Assessment** Section 4.5.5 (Page 27) | All older people identified as frail to have a timely CGA performed and documented in their permanent health record that is accessible to both primary and secondary teams | • Does CGA form part of a formal SGS pathway?  
• Does CGA lead to the development of a coordinated and integrated plan for treatment and long-term follow-up?  
• Are all components of CGA available? |
| **Specialist Geriatric Ward (SGW)** | Each hospital receiving acutely ill older adults must have a dedicated SGW with | • Has the need and capacity for SGW been determined? (# frail |
| **Section 4.5.6**  
(Page 28) | **appropriate staffing levels and a designated Interdisciplinary team** | (24% of >70 ED admissions) x 18 days?  
• # older person with frailty admitted to SGW?  
• Does admission to SGW form part of the care pathway?  
• Is there an inclusion/exclusion criteria to SGW?  
• Is the SGW adequately staffed with appropriately skilled/educated cohort of SGT (Chapter 6)? |
|---|---|---|
| **Inpatient Rehabilitation**  
**Section 4.5.7**  
(Page 29) | **Each hospital had access to onsite and off-site rehabilitation beds and delivers a structured rehabilitation programme for older people** | • Is there access to rehabilitation onsite?  
• Is there access to rehabilitation off site?  
• Is there a referral pathway established and agreed across the SGS?  
• Is the rehab programme provided consistent with the description of rehabilitation as outlined in the Acute Model of Care (Chapter 5) |
| **Discharge Planning**  
**Section 4.5.8**  
(Page 29) | **A systematic approach to discharge planning will be facilitated by admission of the older person with frailty to the SGW with an SGT. Each hospital to have an SGT, with clear responsibility and processes for CGA, integrated discharge planning, and communication with the older person and professionals in other care settings** | • Is there a systematic approach to discharge of the older person with frailty that is consistent with the Acute Model of Care and the Code of Practice for Integrated Discharge Planning?  
• Are discharge plans (which include EDD and discharge destination) initiated within 24 hours?  
• Are EDD’s proactively managed and how is this evident?  
• Are there regular Interdisciplinary team discharge planning meetings?  
• At what stage does planning with the family commence?  
• How do you flag a delayed discharge?  
• What are the causes of delayed discharges in your site?  
• Do patients return to the acute service upon completion of rehabilitation (prior to accessing HCP)? |
| SGS Outpatient & Rapid Access Clinic   | Do the hospital employ a discharge by 11am policy?  
| Section 4.5.9 (Page 30)              | • Are discharge destinations recorded?  
|-------------------------------------|------------------------------------------|
|                                    | • What OPD services are provided for older people?  
|                                    | • What nurse-led clinics are provided?  
|                                    | • Are referral pathways to OPD clinics outlined clearly?  
|                                    | • Are rapid access slots available for referrals from ED/AMU/SGS/Community?  
|                                    | • Is there a case management approach to manage the needs of older people with complex needs across acute and community service interface?  
| Ambulatory Day Hospital on the acute site | Each SGS will provide an outpatient service which encompasses sub-speciality clinics with rapid access slots for urgent referrals  
| Section 4.5.10 (Page 30)            | • Are referral pathways to the DH outlined?  
|                                    | • Are rapid access slots available for ED/AMU/SGS/Community?  
|                                    | • Is CGA carried out in the DH?  
|                                    | • Is access to diagnositcs available?  
|                                    | • Is there an MDT in place in the day hospital?  
| Outreach services e.g. to Long-term care residential facilities | Each SGS will provide an outreach service, prioritising residents in long-term care referred by the GP or medical officer. The outreach service will also liaise with Psychiatry of Old Age (POLL) and support training and education of community based staff  
| Section 4.5.11 (Page 31)            | • Does the SGS provide an outreach service to long-term care facilities as outlined in the Acute Model?  
| Working with community services      | The establishment of SGTs in acute hospitals will facilitate communication with GP’s and PCT’s. A single access point will be established to support referral. Outcome of hospital assessment and plan of care will be communicated in a timely manner to referral source.  
| Section 4.5.12 (Page 32)            | • Is communication across services working effectively in relation to the referral and discharge of the older person with frailty?  
|                                    | • Is there access to a case management approach for older people with complex needs?  

**Supporting frailty at the front door using Integrated models of care**

In addition to the core models of older care provision supported and developed through the NCPOP in 2012, increasing focus has developed on the use of integrated models of care that support timely access to CGA and supported discharge. These models emphasise the need for a case management approach to the needs of older people with complex needs. Essentially case management models ensure that older people and...
their carers have access to a point of contact to assist with navigating the system (especially at time of crisis e.g. unwell carer, need for respite). They have been demonstrated to support care in the community, reduce need for unplanned admissions and support longer term care planning in the community setting (Goodwin, 2014). Successful adaptation of the acute floor model should ensure that where case management models to support needs of older people have / are being developed that they are a primary source of information and contact regarding the older person. The case manager should also be included in MDT discussions regarding discharge planning and ongoing care needs.

**Benefits to Implementing the Model of Care:**

- Patient outcomes and independence would be optimised
- Older People would have access to alternatives to care other than acute hospital admission, NCPOP Categorization of Short Stay Beds (HSE and RCPI, 2016).
- There would be a shift of care to the community, reserving acute beds for patients who require specialist inpatient care
- There would be clear defined pathways in hospitals with minimum lengths of stay
- There would be clarity around designated use of the offsite and short stay beds
- Across all the care settings, interdisciplinary staff would have:
  - Appropriate undergraduate education to enable them to take care of older people
  - Access to decision support tools to assist them in decision making
  - They would collaborate on Comprehensive Geriatric Assessment (CGA) & optimise patient outcomes and independence
- Better patient outcomes including:
  - More patients discharged home
  - Reduced dependency
- Overall reduction in the acute inpatient bed days through the following:
  - Early identification of “frailty” or those at risk of frailty in the ED and AMU
  - Reduction in inpatient average length of stay
  - Reduction in delayed discharges
  - Reduced admission rates

**Critical Factors Affecting Implementation:**

- National policies which support healthy ageing, including sheltered housing, mixed communities, support for carers
- Analysis for service planning: demographic trends, especially increasing numbers of frail older people living with frailty; social factors such as living alone, isolated area, carers
- Measurable quality standards for all components of the service
- Management and service structures to provide coordinated interdisciplinary care
- Adequate resources – services and staffing – across care settings
- Access to services - clear pathways of referral as well as the capacity to respond quickly and appropriately to care needs; physical access to service settings
- Continuing education, training and development for all grades of staff
- Accurate and accessible data collection to monitor service delivery and outcomes, and plan service improvements
Ensure That the Needs of Older People with Frailty are Addressed Using Interdisciplinary Approaches

**Interdisciplinary Working**

Interdisciplinary teams work collaboratively primarily delivering the care required to facilitate a person’s return to their baseline health status. Part of this work is achieved through discussion of a patient’s status and the development of a plan of care with the patient.

A cornerstone of Comprehensive Geriatric Assessment is interdisciplinary communication and coordination. This has traditionally been delivered using Multidisciplinary Team (MDT) meetings. Adapting these meetings to the urgent care setting, so they augment and do not interrupt the flow of work is important. Innovative solutions to this challenge and alternative ways of conducting these meetings will be necessary e.g. in addition to the regular weekly interdisciplinary meeting, a daily mid morning team board round. It might be helpful to structure the discussion using the domains of the Comprehensive Geriatric Assessment - physical/medical issues; functional/mobility issues; cognition/mood; social support networks and environment (home setting).

**Delivering Comprehensive Geriatric Assessment**

It can be challenging to carry out CGA in urgent care settings because of constraints of time and place or because of the priority of urgent medical treatment (e.g. for septic shock) or resuscitation. But even then, elements of CGA are needed as factors such as mobility, cognition and patient’s wishes at the end of life have an important impact on clinical management. So challenging as CGA in urgent care might be to deliver, it is important, and urgent care services must adapt to meet this challenge, just as they have adapted to meet the urgent needs for stroke thrombolysis or coronary angioplasty.

**Comprehensive Geriatric Assessment (HSE and RCPI, 2016)**

‘a multidimensional, interdisciplinary diagnostic process to determine the medical, physiological, and functional capabilities of a frail older person in order to develop a coordinated and integrated plan for treatment and long-term follow up’
The 4 Main Dimensions Covered in CGA should Include:

- Presenting Complaint
- Past Medical History
- Medication Reconciliation and review Nutritional Status
- Alcohol
- Immunisation Status
- Advance Directives

Physical Assessment

- Activities of daily living
- Balance
- Mobility

Functional Assessment

- Living Arrangements
- Social Supports
- Carer Stress
- Financial Circumstances
- Environment

Social Assessment

- Cognition and Mood

Psychological Assessment

- Presentation of Complaint
- Past Medical History
- Medication Reconciliation and review Nutritional Status
- Alcohol
- Immunisation Status
- Advance Directives

Source: HSE and RCSI (2016) Specialist Geriatric Team Guidance on Comprehensive Geriatric Assessment

The delivery of CGA should not just be about Geriatricians

The delivery of CGA is not just about geriatricians. It should be competency driven and a skill nurtured and developed by all those at the front door of “urgent care”. This requires establishing education and training fellowships that enhance geriatric competencies in other specialties, including Nursing Staff, Allied Health professional staff, Emergency Medicine, Acute Medicine and Surgical trainees.

In this context the provision of a “National Frailty Education Programme” has the potential to be a key lever for change. Through programmes such as these, we can enhance and support an improvement in the understanding, knowledge, identification and management of the cohort of older people most in need of early intervention at the “Front Door”. The programme will also have the potential to develop “Frailty Champions” around the country in hospitals and the community who can act as resources for their Hospital groups and CHOs.

The introduction of “specialty fellowships” will allow clinicians to develop their knowledge of geriatric medicine and the services that they might need to access, improving their skills in assessing older people, especially those with cognitive impairment, and change attitudes and behaviours, e.g. by working in the community setting to breakdown the potential silo mentality that can exist.

The role of the Advanced Nurse Practitioner and development of a gerontological nursing service, and a nursing service that is “age attuned” can also enhance the pathway of care for older people. The NCPOP Strategic Vision and Educational Framework for Gerontological Nursing, due to be published by the end of 2017, supports this new way of working. Clearly we cannot train everyone, well at least not yet, but those that were ‘frail-friendly’ can also act as ambassadors elsewhere in the system.
Embedding Geriatric Services within the Emergency Department

Creating a Frail Friendly Front Door

The aim of the frailty ‘at the front door’ service is try and improve the care received by the frail older people in hospital and reduce unnecessary hospital admissions, lengths of stay and readmissions. The service requires early identification of frailty or at risk of frailty ‘at the front door’ with timely assessment of needs and prioritisation.

Development of clinical processes with a proven record in enhancing patient flow, such as early senior review, early documentation of expected date of discharge and daily communication and decision making by the interdisciplinary team should be at the core of the improvement initiative. As previously mentioned, the service should provide a Comprehensive Geriatric Assessment covering not only medical aspects but psychological, social, environmental and functional assessment. For example; the presence of one or more frailty syndromes – immobility, delirium/dementia, poly-pharmacy, incontinence or end-of-life care triggers a detailed comprehensive geriatric assessment (CGA) on presentation to ED. A dedicated interdisciplinary team works across the emergency department (ED) and acute medical unit (AMU) to assess and arrange care at home where this will avoid admission. The assessment therefore does not only identify, treat and manage the patient’s initial reason for presenting to hospital but also works to reduce readmission rates and the potential future need for long term care, by looking at the patient holistically. It is recommended that ambulatory emergency pathways, with access to interdisciplinary teams, should be available within an adequate response time for older people who do not require admission but need on-going treatment and follow up either with their General Practitioner, Primary Care team or other specialist. The ICPOP teams may act as an additional support services in this regard.

Ambulatory Day Hospital “Hub”

Central to the SGS model of care (2012) is the Ambulatory Care/Day Hospital “Hub”. The hub is the proposed setting for acute ambulatory services for community dwelling older people. It will also function as the coordination, information and training hub for services for older patients, supporting integration between hospital and community based services. In addition it will act as a resource for others involved with the care of older people. The Hub should provide expedited assessment for frail older adults presenting to their GP, and where deemed appropriate, from ED or AMU. This hub may need access to acute hospital services where the main focus will be on keeping the older adult within the environment best suited to their care. It will facilitate the ongoing development of the integrated care services.
Building and Sustaining Influence through Education and Training

We should strive to ensure that all key health care professionals working with older people have frailty as a focus and core part of their continuing education and professional development, as well as in their training.

Given the ageing demographic of people requiring health care, an understanding of frailty and its consequences should be a core requirement for all health care professionals at the front door of “urgent care”. This should be competency driven and a skill nurtured and developed so that we truly develop and sustain an “age attuned” health care environment.

Against this backdrop, The NCPOP has developed a Frailty Education Programme for Older People in conjunction with the Irish Longitudinal Study in Ageing (TILDA) and sponsored by the Office of the Nursing & Midwifery Services Director (ONMSD). We are working jointly with the Integrated Care Programme for Older People, and collaborating with the National Clinical Programme for Acute Medicine (NAMP) and Emergency Medicine Programme (NEMP) on this key initiative to support early recognition of frailty, improved healthcare management and better health outcomes for older people living with frailty. The programme is currently in pilot phase, commenced in February 2017 and being piloted across three Hospital Groups and corresponding Community Healthcare Organisations (CHOs) areas. Initially, the aim is to develop a cohort of nurses working in Acute Medicine, Emergency Medicine, Older People’s services and the community to provide healthcare professionals with an enhanced understanding of frailty and frailty assessments and expand to interdisciplinary training in the near future.
Learning outcomes from the programme will provide participants to:

- Identify clinical models underpinning frailty;
- Recognise patients who are frail or at high-risk of becoming frail;
- Understand the role of frailty assessment tests in the identification of frailty;
- Apply their knowledge of frailty to effectively manage frailty and help to improve health outcomes;
- Gain an overview of The Irish Longitudinal Study on Aging, it processes and how its findings inform policy.

Examples of Best Practice - Acute Frailty Pathways

The development of an acute frailty pathway is a key component of the NCPOP model of care (HSE & RCPI, 2012), NCPOP Specialist Geriatric Team Guidance on Comprehensive Geriatric Assessment HSE & RCPI (2016), and ICP POP 10 steps framework (HSE, 2016). In 2016 and 2017, funding was provided to CHO/Acute Hospital areas to progress an integrated care framework that includes the development of care pathways (including frailty pathways) that are attuned to the discrete needs of older persons. Sites included in this allocation have begun gathering data, and early indications show changes in practice are increasing discharge rate, and creating capacity when required.

Conclusion & Key Considerations

Older People at risk or living with frailty are identified as soon as they present to the ED or directly to assessment services, and receive specialist, high quality, person-centred care on the non-elective pathway. They are discharged without delay when their acute care is complete, with the right level of support to continue their recovery and rehabilitation in their own home (NHS Improvement, 2017).

- Adopt a whole system perspective, building upon a shared common vision - quality care for older people across the whole patient pathway (acute and community settings);
- Evidence based models, specifically the Acute Model of Care (NCPOP, 2012) and Mental Health Model of Care (NCPOP, due to be published in 2017) describe key components of care journeys for older people;
- Access to a senior decision maker to identify older people a risk or living with frailty at the earliest possible point in their urgent care journey;
- Older People at risk or living with frailty should be screened at the front door using an evidence-based assessment tool (for example, PRISMA 7, the Rockwood Clinical Frailty Scale);
- There is an interdisciplinary team to provide holistic assessment and management of older people (through Comprehensive Geriatric Assessment - CGA);
- The frailty pathway is embedded in processes in the ED, AMUs and on specialty wards;
• Out of hours services are identified to support timely effective discharge;

• Older People at risk or living with frailty should be actively involved in their care and the provider able to demonstrate shared decision-making/patient-centred care.

• Older People at risk or living with frailty should be routinely asked what is most important to them and their responses clearly documented; (e.g. NCPOP/HSE QID “What Matters to You” initiative);

• Continual collaborative work with integrated care teams, evolving governance groups and networks to implement integrated pathways for older people;

• Education and training for all health care staff to ensure a “frailty attuned” workforce with the skills and competence to provide care that meets the need of older people (e.g. NCPOP Frailty Education Programme)

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Appendices

Appendix One – Worthing Hospital (UK) Emergency Floor Pathway

Emergency Floor Patient Pathway
Existing Building + Constraints
Appendix Two – Integrated Care Programme for Older People – 10 Step Framework
References:


Halloran, M. (2017) *Risk Stratification Based on Frailty Prevalence Data from Wave 1 of TILDA*, Irish Longitudinal Study on Ageing, TCD.


HSE and RCPI (2016) National Clinical Programme for Older People, *Categorization of Short Stay Beds*.


