Managing the End of Life Needs of Frail, Older Adults in the Community: The Role of a Hospital Based Community Outreach Team for Older People

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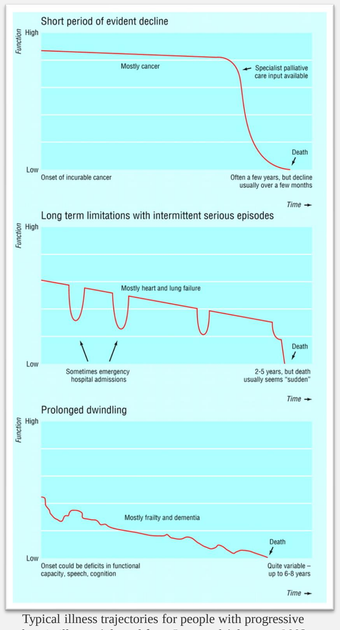
Background

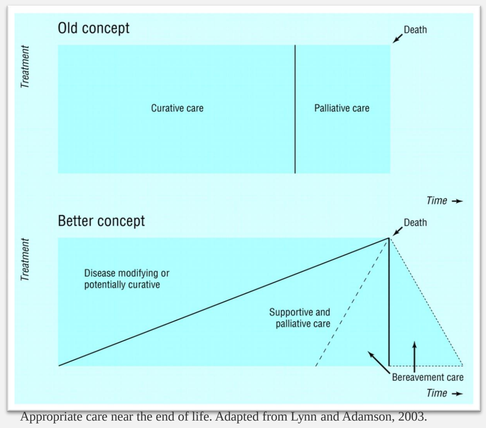
- Ireland has the longest life expectancy in the European Union (84 years of age for women, 81 years of age for men). However, most adults face chronic disease and dependency in the years prior to death.
- Frail, older adults often suffer from chronic pain, depression and/or anxiety and falls, which are often underassessed and undertreated.
- Older adults living with significant care needs require a healthcare workforce that can help provide support to those living in the community, with significant responsibility falling onto families.
- Our current healthcare systems are designed around periods of acute illness and are ill equipped to care for the needs of multimorbid and frail adults with chronic and worsening mobility, cognition and function. In addition, these patients are more likely to spend significant amounts of time in acute hospitals nearing the end of their lives, not without significant risk and often with poor outcomes and costly health care expenditure in the period just prior to death.
- According to The Irish Longitudinal Study on Aging (TILDA), Ireland has a high proportion of hospital deaths, indicating inadequate community and home care supports.
- Recognizing patients who are likely to benefit from supportive and palliative care approaches in the community with a goal to die at home can be done using a combination of tools and based on advanced care planning discussions.
- The uncertain trajectories towards death associated with chronic organ failure and prolonged dwindling (as described by Lynn & Adamson, 2003) make advanced care planning and care management paramount.

Mercy University Hospital – Community Outreach for Older People

- The Department for Older Persons Services at the Mercy University Hospital recognised many in-patients with advanced chronic disease and advanced frailty who had multiple recurrent hospitalisations towards the end of their life.
- There is a deficit of specialist supports in the community to help patients, families and primary care services deal with some of the complex issues of advanced chronic disease and frailty management.
- The existing community palliative care services do not have specific expertise in the presentations with advanced frailty. Those patients with a prolonged dwindling trajectory towards death are particularly difficult to manage in the community for existing palliative care and primary care services.
- Due to the deficit in existing services, in 2021, our department for Older Persons Services allocated a team consisting of both medical and nursing expertise staffed by a Registrar and Advanced Nurse Practitioner in Frailty, under the governance of the existing consultants in geriatric medicine, to form an outreach service.
- Our team have expertise in supporting advanced care discussions with patients & their families.
- Our team practises a patient centred care that integrates the preferences and needs of both patients and families especially at the end of life.
- Our team provide services & support into the patients home bringing the expertise to the patient



Typical illness trajectories for people with progressive chronic illness. Adapted from Lynn and Adamson, 2003.



Appropriate care near the end of life. Adapted from Lynn and Adamson, 2003.

Case Study 1

Z - 83 year old male

- Multiple co-morbidities including enlarging meningioma and GU malignancy;
- GU malignancy and surgery; chemotherapy 3 months
- Family report progressive decline post treatment
- **11-18th September** admission with delirium, found to have metastatic disease
- **5-9th October** admission with malaise, fatigue and diarrhoea, raised inflammatory markers with negative workup, likely related to underlying malignancy
- **21st October** Family contacted Geriatric Service with mobility, functional decline soon after discharge. Found to have mild AKI, thrush, stopped multiple meds; referred to ICT, linked with PHN re increasing HH, linked with urology and oncology and determined for palliative management, linked with GP and community palliative care
- Multiple visits over **end of October, early November,** gradual decline, poor oral intake, delirium, LRTI, actively dying, commenced on CSCI
- **7th November died at home with family**

Case Study 2

Y - 94 year old female

- Limited comorbid disease; osteoporosis, rib fractures while vacationing in Turkey
- **24-28th April** Admission with weakness, fall 2 weeks prior, dark stools x 2. Hb 14, bloods unremarkable. CT brain gross atrophy. Mobilizing with frame. 3 antihypertensives stopped
- **13th May** Seen on discharge by team, now bedbound. Developed epigastric pain, planned readmission
- **20th May-26th May** OGD (PUD) and Comprehensive Geriatric Assessment
- **2nd June** Seen on discharge again; Moblizing with stick/frame early June.
- **3rd August** family contacted service with decline in mobility, poor intake. Desire to remain at home
- **18/8; 25/8; 1/9; 9/9; 14/9; 16/9; 20/9; 28/9;** link with community palliative care
- **1st October died peacefully at home**

Case Study 3

X- 84 year old male

- Multiple co-morbidities: Dementia, CKD, Stroke disease, T2DM c/b HHS; severe frailty, known to entire department for older people. Multiple admissions
- Admission 27/5-9/6.
- **19 Oct** ; 2 week diarrheal illness; Cr 198->345
- Increasing bed bound; hospital bed/downstairs living; constipation; decline in oral intake, LRTI
- **26/10; 9/11; 17/11; 30/11; 8/12; 10/1**
- **22nd January died at home**

Case Study 4

W - 85 year old female

- Hx of COPD, recent commencement LTOT, colovesicular fistula with laparoscopic colostomy March, prolonged hospitalization and rehabilitation, discharged mid May
- Month long hospitalization discharged **late August** for delirium, LRTI; discharged with plan & desire to avoid rehospitalization
- **27th September**; decline since discharge; poor oral intake, hallucinations; med adjustment, revisit 48 hours, stable; multiple phone contacts following week re: agitation, poor sleep
- **10th October** family felt they were in crisis; adjusted meds, hospital bed downstairs; feel patient at EOL care, communicated with community palliative care who commenced CSCI
- **13th October died at home**

Case Study 5

V - 90 year old male

- End stage COPD on LTOT, multimorbid, living alone, cognitively good, very clear about wishes to die at home, carers= 2 excellent nieces, supportive GP
- Admission **25th June- 11th of July** with IECOPD, nosocomial COVID
- Readmitted **13th of July to 10th of August** with fall, aspiration pneumonia
- Upon discharge, mobilizing with stick, independent for pADLs
- **16th Aug 2022** post discharge visit, commenced oromorph for dyspnea
- **31st Aug 2022** UC visit; Fall night before, head lac, humerus xray
- **6th September** visit; 4 falls since discharge, worsening SOB, commenced Butrans patch, eating well
- **16th September-** significant fall, bedbound, nieces providing 24 hour care; community palliative care actively involved
- **24th September died at home**

Process of care – Community Outreach Team for Older People

Patients known to older person service in Mercy University Hospital
With advanced frailty or advance chronic disease
Multi-morbidity & recurrent admissions
Recurrent frailty syndromes: falls; delirium; reduced mobility

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Cases discussed between consultant geriatrician, outreach registrar and ANP
First home visit usually takes place within 24 hours of hospital discharge
Transition of care & support in complex case from inpatient to home
Also the transition to a more supportive and palliative approach with advanced care planning
Identify any potential challenges

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Comprehensive assessment, medication review, assessment of the home environment
Education on end of life, advanced care planning to anticipate needs
Family & patient support
Access hospital diagnostics and planned admission where required
Communicate with Public Health Nurses, General Practitioners and Community Palliative Care
Bring gerontological expertise into the community & into patients home

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- Support patients and families through periods of deterioration until they stabilize again in a 'new normal'
- Support patients as they begin the process of active dying, help patients & families realise their preference for care such as dying at home
- Families and carers are given a telephone number which the team support weekdays between 9 am and 5 pm.

Key learning

- Addressing end of life care for multimorbid patients living with severe frailty is a significant challenge for healthcare systems worldwide.
- Complex frail patients approaching the end of life can be identified in hospital
- An outreach service from hospital to community can be successful
- Collaborating & working with community and hospital colleagues can provide a patient centred approach to care
- A hospital based team outreaching to the community can "schedule unscheduled care" & organise investigations and assessment in hospital if needed
- A small team can provide care for over 120 highly complex patients per year in the community with multiple reviews in the patients home and telephone support for carers
- Significant savings and better care with expansion of similar services