

# MORAY MEDICINE FOR ELDERLY


DGH and Community Developments


A decorative graphic consisting of several parallel white lines of varying lengths, slanted upwards from left to right, located in the bottom right corner of the slide.

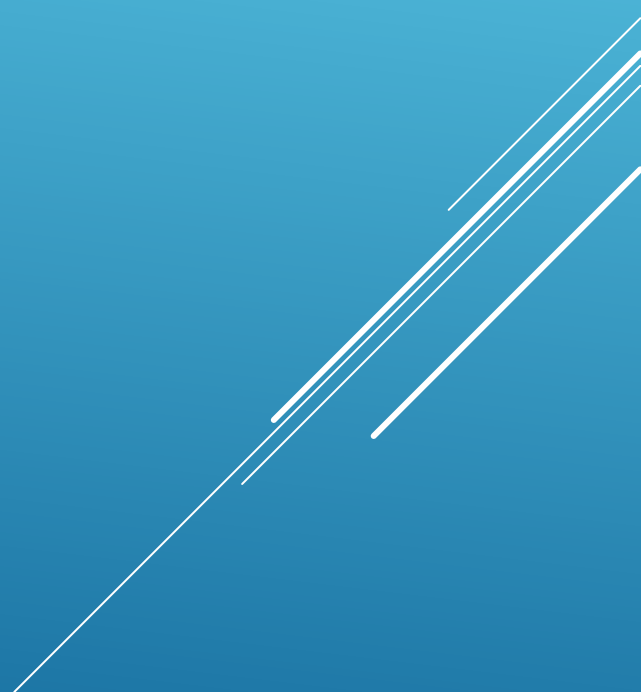
# TAYSIDE MODEL

Cesar Rodriguez (Medical Director Older  
People's Board)

A decorative graphic consisting of several parallel white lines of varying lengths, slanted upwards from left to right, located in the bottom right corner of the slide.

- Community based Geriatricians model for Moray with hospital in-reach
  - Same teams working in and out of hospital so that knowledge of patient in community preserved
  - Work at the front door of Grays to have CGA performed within 24 hours to identified clinical presentations
  - Development of a Frail elderly unit via Acute Frailty team leading to rapid intervention, shorter stay and safer discharge
  - Development of skills mix to look after complexity (very different from Acute or managing LTC's singly)
- 

- "Pull" model to allow early transfer to Community hospitals or even straight discharge home
  - Integration of Elderly Medicine and Elderly Mental Health under one manager
  - Specialty Docs/Trainees working in the system
  - Improved management of Delirium/Dementia pathways (via Nurse Practitioner)
  - Development of Nurses...2 x Nurse Consultant model in Tayside....also 2 ANP's in Geriatrics in Angus
- 

- Alignment of consultants and teams with Practices/Localities with regular MDT meetings to evaluate those at risk of early decompensation (including OP CMHT)
  - MDT's in community can lead to reduced admissions, decreased occupancy and improved "pull" model
  - Pharmacist for Elderly - significant number of admissions in elderly are medicine related
  - Qualitative data (patient and family narratives) as important as quantitative data (bed occupancy etc)
- 

DONALD NEWNHAM

UCD Dept Medicine for Elderly, ARI

A series of several parallel white lines of varying thicknesses, slanted diagonally from the bottom-left towards the top-right, located in the lower right quadrant of the slide.

# 1. Front Door/Acute Admissions.

Identification of those patients most likely to benefit from early Elderly medicine input is key.

Adoption and robust interpretation of specific criteria (e.g. HIS Frail, Bournemouth criteria etc) preferably by a Pull model whereby these patients are positively identified by DOME staff with a rapidly expedited CGA and transfer to specialised area facilitating early assessment and holistic person centred specific planning.

## 2. Current in-patients

Development of a 2nd Pull model to enable early and safe discharge back to home community either via Community hospital or supported discharge directly to home.

Ideally looked after by the same consultant/team who have responsibility for the Community Hospital/Locality/Practice team.

Makes care more seamless.




### 3. Acute Care at Home.

Development within each IJB area of bespoke supported mechanisms of safe care for unwell patients at home. Includes provision of I.V antibiotics and fluids. Requires point of care diagnostics, medical and nursing assessment, DN support, SW and carer provision.

Moray model to be developed.

## 4. Community Hospitals.

Consultant allocated to each community hospital and to work in conjunction with local GP's and teams to develop supported ward rounds, Pull Model (as in 2) and improved community interfacing.

A decorative graphic consisting of several parallel white lines of varying lengths, slanted upwards from left to right, located in the bottom right corner of the slide.

## 5. GP/Locality Teams, Upstream Model.


Consultant allocated to practice/locality with regular tabletop meetings to identify those patients for admission prevention and alternative investigation, treatment and care planning provisions to enable safe maintenance at home.

Teams likely to involve GP, DN, NP, Pharmacist, SW Care Manager, Dementia Coordinator (POA input), Well Being Coordinator and links to AHP.

6. Incorporate closer working with Psychiatry of Old Age both in hospital (liaison posts) and in the community with similar attachments of this service to GP/Localities and joint attendance at tabletop meetings.

This may require negotiation and re-design of this service in each HSCP.

# SO FAR IN MORAY

- 1.6 WTE – (longer term aim for 2.6)
  - ACE Ward – 10 beds in Ward 7
  - Education in Pull model and CGA
  - HIS Scotland FRAIL tool
  - Therapy Team and Nursing Team
  - Dynamic Discharge Approach
- 
- A decorative graphic consisting of several parallel white lines of varying lengths, slanted upwards from left to right, located in the bottom right corner of the slide.

# IN THE COMMUNITY

- Community Hospital Input
  - GP tabletop meetings with every practice
  - Domiciliary Visits
  - Building extended MDT in Primary Care
  - Input to Care Homes/Hanover/Jubilee
- 
- A decorative graphic consisting of several parallel white lines of varying lengths, slanted diagonally from the bottom right towards the top right, set against a blue background.

