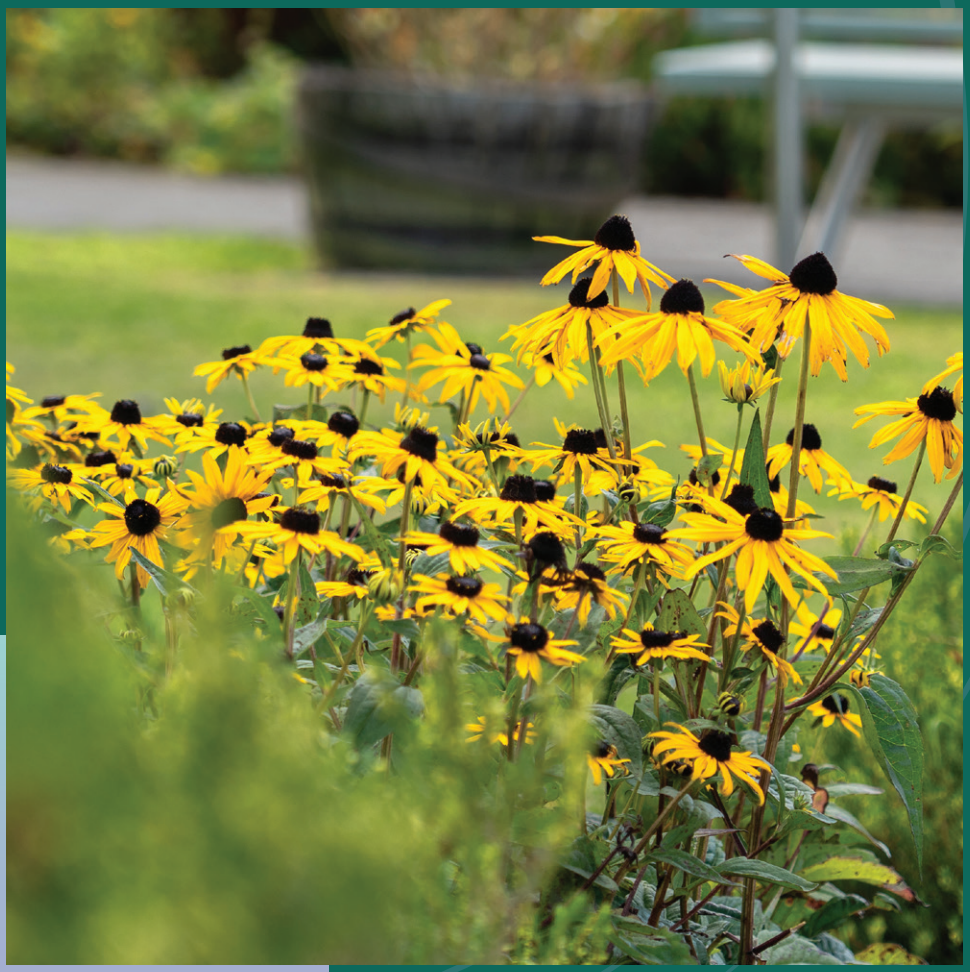
Model of Care for Older Adults at Bloomfield Hospital

Psychiatry of Later Life



Bloomfield
HOSPITAL

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Foreword by the Clinical Director

As we progress in understanding and addressing the complexities of healthcare for older adults, it is increasingly clear that frailty is not simply a consequence of aging, but a multifaceted syndrome that requires careful attention and a tailored approach. The Later Life Model of Care that we present in this document reflects a growing commitment to providing holistic, person-centred care for our aging population.

Frailty is a dynamic state, marked by vulnerability to adverse health outcomes such as falls, disability, hospitalisation, and death. It can affect physical, mental, and social wellbeing, often in combination, and requires us to look beyond traditional disease-based models of care. As clinical professionals, we must be adept at identifying frailty early, managing its progression, and supporting older adults in maintaining as much independence and quality of life as possible.

This model recognises the importance of a comprehensive approach that spans the full spectrum of care. It emphasises prevention, early intervention, and the integration of services to address not only physical health but also mental, emotional, and social needs.

By providing a cohesive framework, we can ensure that older adults are supported in a way that is both individualised and collaborative, engaging the full breadth of healthcare professionals, family members, and community resources.

At the heart of this model lies the belief that frailty is not an inevitable fate but a condition that can be managed effectively with the right interventions. We advocate for a shift towards proactive care, where frailty is identified early, and individuals are empowered to make decisions about their own health. This person-centred philosophy is the foundation of the care we provide, ensuring that the needs and preferences of each individual are met in a respectful and compassionate manner.

I hope that this model enables us to offer better outcomes for older adults living with frailty and empowering our teams to deliver the highest standard of care. It is a privilege to work alongside committed professionals in this field, and together, we can make a meaningful difference in the lives of those we care for.

Dr David Denton

Clinical Director
Bloomfield Hospital

Introduction to Bloomfield Hospital

Founded by the Quakers in Ireland in 1812, Bloomfield Hospital is an independent, not for profit, 113 bedded facility located at the foot of the Dublin mountains in Rathfarnham Dublin 16. It commenced its service provision in 1812 and was originally located in Donnybrook, until 2005 when it moved to its current location, which provides a state-of-the-art environment for the care and treatment of its patients and residents.

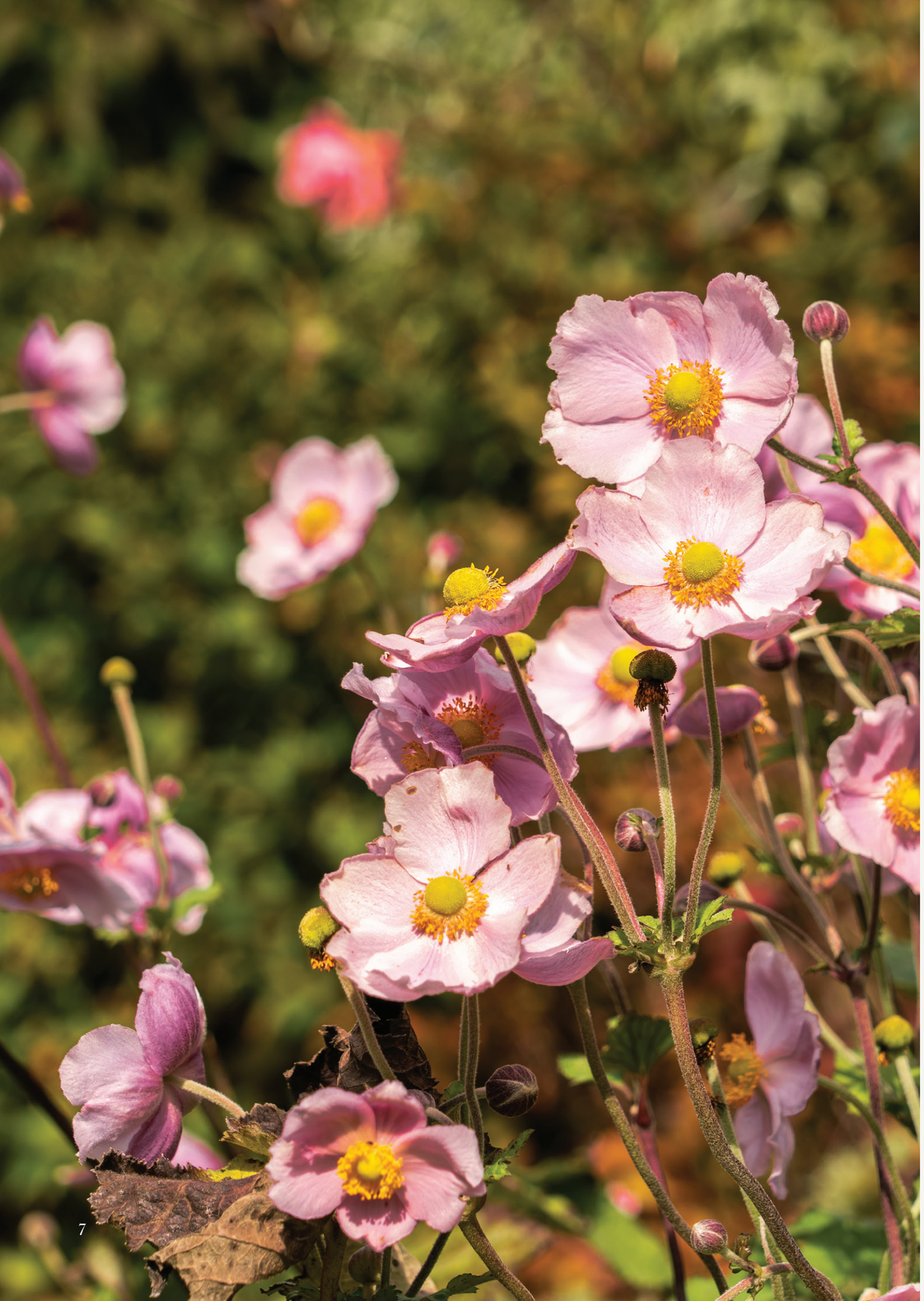
Psychiatry of Later Life Service

Caring for older psychiatric patients requires a specialised, multidisciplinary approach, considering the complex interplay between mental health, physical health, and social factors in old age. The model of care for elderly psychiatric patients focuses on providing holistic and integrated care, tailored to meet their unique needs.

Here's an outline of this model:
We provide long-stay specialised psychiatric care for older adults and provide support to their caregivers and families. We work closely with a variety of specialists including later life psychiatrists, general practitioners, neurologists, geriatricians, nursing and a variety of allied healthcare professionals to ensure a combined biopsychosocial approach for everyone within our services. Care and therapies focus on dignity, inclusion and quality of life.

The psychiatry of later life team cares for those with:

1. New onset mental illness in adults over the over the age of 65 years
2. Those with life-long severe and enduring mental illness who have grown older and have developed cognitive disorders such as MCI or Dementia
3. Many types of neurodegenerative disease such as Parkinson's and Huntington's disease
4. Advanced care planning with support from palliative care services.



Background

Ireland has an aging population and this is projected to increase from 460,000 in 2006 to approximately 1.4 million individuals in 2046.

In Ireland there is expected to be an increase in the percentage of older men in the general population from 9.7% in 2002 to 13.9-14.1% and an increase in older women from 12.5% in 2002 to 15.8-16.4%.

Dublin city and county will be home to almost 24% of males and almost 26% of females over 65 years. A large proportion of this increase will be in the 65-74 years group.

Mental Health issues are relatively common in those aged over 65 years with the incidence of Dementia at 5% at 65 years and increasing by 5% every 5 years until it plateaus around the age of 95 years.

Individuals may have suffered from psychiatric disorders all their lives before the age of 65 such as depression, schizophrenia, bipolar disorder, anxiety and substance misuse. Older adults may develop late onset psychosis or mood disorders as well as cognitive disorders.

Aims and Objectives

Our aim is to create a model of care that is focused on our residents over 65 years who have a variety of psychiatric conditions including severe and enduring mental illness who, as they age, may develop comorbid cognitive disorders which will require a more specialised approach.

We strive to promote independence for our patients and residents as long as possible and to support them to live as full a life as possible, whatever age they may be, with the support and help of family, friends, and allied health professionals.

We deliver person centred, holistic, planned care that is delivered in a safe, appropriate, comfortable and homely setting.

We aim to be a recognised centre of excellence using both national and international best practice.

We use validated outcome measures to assess and validate our work, placing a focus on our service users and their family's experience of service provision.

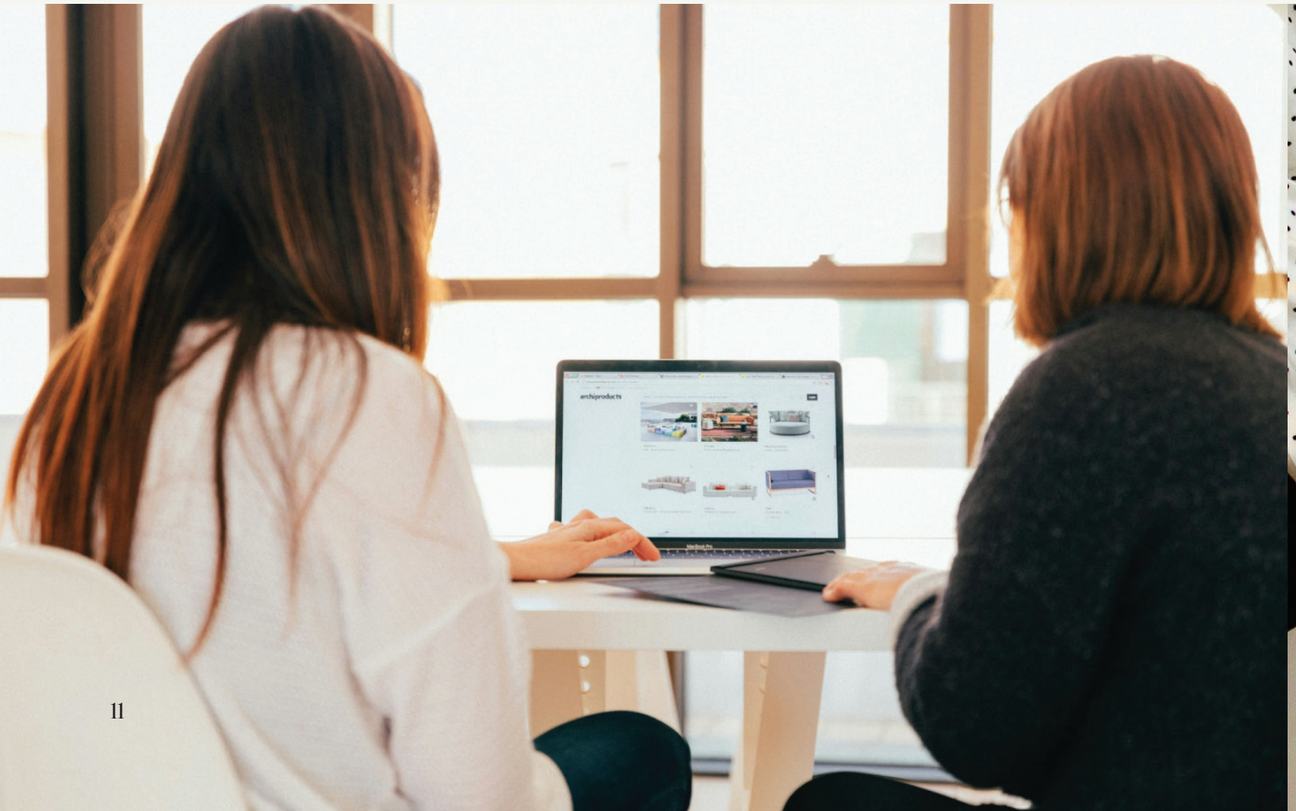
We are committed to ongoing training and education for our healthcare professionals to enhance treatment programs for the continued improvement of outcomes for patients and residents and the overall enhancement of their quality of life.

We also provide ongoing support and education for family members and caregivers through our family meetings and psychoeducation through our ongoing relationships and partnerships with third sector organisations.

Clinical Governance

Healthcare teams are accountable for the quality, safety and satisfaction of patients in the care they deliver. To enable us to continually improve our service and maintain high standards of care, we ensure that clinical governance is in place and applies measures to our work which include: quality improvements, staff training, development and education, clinical audits, which ensures risk and compliance management are strictly followed. Our psychiatry of later life team come under Bloomfield governance structures with regular clinical governance meetings.

Clinical Governance			
Quality Improvements	Staff Training	Development and Education	Clinical Audits



Referral Process

We accept referrals from primary care teams, general practitioners, geriatricians, neurologists and psychiatric mental health teams from across the country. We also accept admissions/transfers from other acute services. We accept those with either a voluntary or involuntary status as an Approved Centre.

Pre-Admission Process

1. A completed referral form is received with accurate, up to date information on the patient, including a completed risk assessment.
2. The referral is pre-screened and an assessment is arranged with the referring team.
3. If further information is required, the service will be contacted immediately with a request to provide it.
4. A specialist clinician and a senior member of the nursing team will assess the patient. In some cases, other members of the multidisciplinary team will contribute to the assessment process as appropriate. Assessments take place following receipt of the completed referral form and relevant information.
5. Following the assessment, a decision to admit will be made at an admissions meeting and an appropriate bed will be assigned to the patient.
6. Admission to the service is conditional on approval of funding from the referral source.
7. Please see our website for the most up to date information on referrals and admission available at www.bloomfield.ie.

Comprehensive Assessment

We provide the following assessments during a residents stay including:

A Comprehensive Geriatric Assessment (CGA) which is a systematic evaluation of frail older persons by specialised health professionals.

Holistic Evaluation
A thorough assessment of mental, physical, cognitive, and social factors is conducted. This includes screening for common psychiatric disorders in older adults, such as depression, anxiety, dementia, and psychosis, alongside medical conditions.

Cognitive Testing
Neuropsychological assessments to identify cognitive impairments such as dementia or mild cognitive impairment (MCI).

Functional Assessment:
Evaluation of the patient's ability to perform activities of daily living (ADLs), which can affect their overall well-being.

Falls Risk Assessment Tool (FRAT):
The Peninsula Health Prevention Service developed the FRAT. Previous assessments of research indicated fall risk variables among older community members. It was a two-year research project. The FRAT is completed by nursing staff in hospital and discussed at MDT. It is useful in providing a focal point for all falls related information. It helps in predicting the fall risks of individuals with accuracy. It identifies people who are most likely at high risk and aims to direct resources towards them. The FRAT can target preventive measures for those identified at medium or high risk of falling.

Modified Barthel score:
The Barthel index is the most widely used measure of activities of daily living (ADLS). It measures the likelihood of being able to live at home with a degree of independence following discharge from hospital. Ten basic activities of daily living (ADL) are captured: bowels, bladder, grooming, toilet use, feeding, transfers, walking, dressing, climbing stairs, and bathing.

Malnutrition Universal Screening Tool (MUST):
The MUST is a five-step screening tool to identify adults, who are malnourished, at risk of malnutrition (undernutrition), or obese. It also includes management guidelines which can be used to develop a care plan.

Multidisciplinary Team Care

Assessment Tools

(i) Nursing Assestsments:

a) Activities of Daily Living (ADLs)

This is to assess a patient's functional status. They are the basic tasks, which must be accomplished every day for an individual to thrive. They are broken down into categories.

- **Maintaining a safe environment**
  We provide support for residents to be orientated to the ward, their bedroom is clearly signposted, appropriate lighting is provided, toilets signposted etc.
- **Communication**
  We assess the resident's ability to use language, use a telephone, send and receive letters and aid in helping them to communicate unmet needs. We often manage residents with expressive and receptive dysphasia.
- **Breathing**
  Common cardio-respiratory conditions such as lung cancer, chronic non-malignant lung disease, and heart failure increase in prevalence with age and are common causes of breathlessness (60% – 88% with heart failure and 90% – 95% with late-stage chronic obstructive pulmonary disease). Some of our residents require supplemental oxygen.
- **Eating and drinking**
  We assess residents' ability to prepare a meal, check that they able to feed themselves, make choices of menu, and assess whether they require a special diet due to risk of aspiration or require nutritional supplements.
- **Washing and dressing**
  A regular shower, grooming, oral hygiene and nail care routine is important. We maintain privacy and dignity and assess the way that residents like things done.
- **Physical observations**
  We monitor physical observations routinely. Changes in temperature, blood pressure / pulse / respiratory rate could indicate sepsis. Infection can increase the risk of delirium.
- **Toileting**
  We monitor for any urinary or faecal incontinence. Bowel movements are closely observed as constipation can be a risk factor for delirium.
- **Mobility**
  We assess a resident's ability to weight bear and move from one position to another. We assess their ability to transfer from a bed to chair or to a wheelchair. We explore whether they need a walker or other assistive aids or can walk independently.
- **Working and playing**
  We assess the resident's ability to engage in activities.
- **Expressing sexuality**
- **Sleeping**
- **Death and dying**

This assessment is used in conjunction with five additional determining factors:

- **Biological**
  This considers the patient's current and past history, strengths and vulnerabilities.
- **Psychological**
  This considers the individuals core beliefs and cognitive functions, and how these effect the individual's ability to execute activities of daily living independently.
- **Sociocultural**
  We consider the person's history and cultural beliefs, and the beliefs of those around them. This can affect recovery and the ability to function independently.
- **Environmental**
  The factors consider how the environment impacts healing and wellness.
- **Financial**
  We assess the resident's ability to access personal funds, public and private programmes and insurance to accomplish health and wellness.

A combination of both assessment tools forms the foundation of a care strategy for the patient and helps to empower individuals when discussing care goals with the MDT.

Difficulties with ADLs often correspond to how much help, supervision and hands on care an older person needs. For each ADL, residents can vary from needing just a little help, such as reminders, to full dependency. This may require partial or full assistance with tasks.

b) Abbey Pain Scale
This is a standardised pain assessment tool developed for use in dementia and non-verbal patients. Pain assessment is difficult in those with Dementia, a group believed to be undertreated for pain. Changes in facial expression, grimacing, behavioural changes such as restlessness, agitation, vocalisation and an increased heart rate can indicate pain.

c) Skin Integrity Assessment
The patient is fully examined for skin abnormalities. It requires visual inspection of the skin from head to toe with particular emphasis on body prominences and skin folds.

d) Waterlow Assessment
The Waterlow score estimates the risk of developing pressure sores.

e) Barthel Assessment
This measures the performance of Activities of Daily Living. Each performance item is rated on a scale given a number of points assigned to each level of ranking. This can identify the dependency level of the patient.

f) FRAT Assessment
This is a risk assessment tool for falls, it helps to identify the risks of falling and is a quick and easy tool to assess an individual's falls risk. This can be used for all individuals you think may be at risk of falling and giving guidance on specific areas surrounding the individuals falls risk.

g) MUST Assessment
This five step screening tool to identify adults who are malnourished, at risk of malnourishment or at risk of obesity. It includes management guidelines, which can be used to develop a care plan.

h) Social Functioning Scale
Measures social skills and performance to cover functions that are important for patients suffering from schizophrenia. It assesses the presence or absence of key skills and social behaviours in the person.

Medical Assessments

a) Medical/Psychiatrist Assessment on Admission
A full physical examination is conducted by a general practitioner, medical officer or Consultant upon admission. This includes an assessment of the resident's history and collateral information, blood tests and other investigations, imaging, cognitive or neuropsychological testing as required.

MDT members are consulted to discuss the assessment of the patient and to reach a consensus agreement regarding the person's diagnosis in individual care plan.

The physician then collaborates with MDT colleagues to provide a person-centred care plan, ensuring:

- Involvement of relevant people and agencies.
- Forward thinking and anticipation of changing needs.
- The use of effective interventions tailored to the individual.
- The quality of life for the individual is upheld and improved upon.
- Regular reviews of the plan and activities.
- Support to caregivers, families and friends.

A team-based approach is essential for managing elderly psychiatric patients due to their complex needs. The team typically includes:

- **Psychiatrists (Later Life or General)**
  Specialise in the mental health of older adults, prescribing and managing psychiatric medications.
- **Geriatricians**
  Physicians specialised in the health care of older adults, focusing on comorbidities and age-related physical conditions.
- **Nurses (General/Psychiatric)**
  Provide day-to-day care and monitor the residents overall health status.
- **Social Workers**
  Address social determinants of health, help navigate care systems, and provide support for family caregivers.
- **Occupational Therapists**
  Help improve functional independence and quality of life.
- **Psychologists and Therapists**
  Offer a programme of psychotherapies tailored to older adults, such as cognitive behavioural therapy (CBT), cognitive stimulation or reminiscence therapy.
- **Pharmacists and technicians**
  Review and manage complex medication regimens, reducing polypharmacy risks.

Integrated Mental and Physical Health Care

Many of our elderly patients are typically frail with multiple comorbid conditions such as diabetes, cardiovascular diseases), making it necessary to integrate physical and psychiatric care. Addressing medication management is critical to avoid drug interactions and side effects, especially considering polypharmacy.

Psychosocial Interventions

Cognitive-behavioural therapy (CBT), interpersonal therapy, and other psychotherapies can be effective in treating depression, anxiety, or trauma in older adults.

Family and caregiver support
Family members often play a significant role in caring for elderly patients and involving them in the care plan is essential. They may benefit from psychoeducation about the condition or medication.

Group therapy and social engagement programs can help combat loneliness and social isolation, which are common in elderly patients.

Pet Therapy
Irish Therapy Dogs is a registered voluntary charity whose approved volunteers and their dogs visit the residents of an assigned Care Centre once per week for approximately one hour to bring them the therapeutic benefits of canine companionship.

We have a dedicated activity centre with daily activities and entertainment providing a rich array of social activities. We provide residents with a timetable and offer a programme of various activities which cater for all tastes and allow for an element of choice.

Environment

Bloomfield Hospital provides care in a specialised long-term care facility for those with the most complex elderly patients with psychiatric conditions. This helps us to fully assess and understand a patient unmet needs over a period of time so that they get the most appropriate holistic care.

All residents in Bloomfield benefit from high quality living environments which include: a sitting/living room, dining area and kitchen within the mixed gender unit. Accommodations are in a range of four bedded units, two bedded units, the majority of the bedrooms are single en-suite. There are assisted bathrooms located on each corridor and all the residents have access to outdoor space.

Donnybrook Unit is the main area that facilitates psychiatry of later life in Bloomfield. It is 30-bed unit, caring for the majority of our patients and residents over the age of 65 years. It was subdivided into two sub-units that allow for those with more dependent needs be cared for together in Douglas Wing. There are outdoor spaces for gardening and relaxation. The unit has a Snozelen Room for those requiring a sensory approach to their care.

Other Facilities provided include:

- Physiotherapy Gym
- Therapeutic Kitchen
- Art Therapy/Men's Shed Room
- Multi Faith Room
- Hair/ Beauty Salon
- Family Room
- Shop
- Reminiscence Corner, Street Scape, Poetry Corner and Art Displays
- Restaurant facilities where patients can eat off the unit.
- Sensory Garden.
- Day Centre with in-house activities for all residents.
- Horticulture

Person Centred Care

This approach tailor's interventions to the individual's preferences, values, and needs. It includes:

- **Respect for autonomy**
  Encouraging patients to be active participants in their care decisions.
- **Cultural and spiritual sensitivity**
  Acknowledging the role of cultural, religious, or personal values in shaping care.

Management of Behavioural and Psychological Symptoms of Dementia (BPSD)

We provide special care for patients with dementia focuses on managing agitation, aggression, depression, or psychosis.

Non-pharmacological interventions are prioritised, including environmental modifications, structured activities, and behavioural therapies.

Medication Management

Bloomfield Hospital provides age-appropriate pharmacological treatment:

- Frequent reviews of medication regimens to minimise polypharmacy and adverse effects in line with MHC guidance.
- Use of antidepressants, antipsychotics, or mood stabilizers cautiously, with consideration for age-related physiological changes in metabolism.
- We review and audit medication strategies via our Drugs and Therapeutic Committee taking into account the most up to date clinical research and evidence as well as regulatory considerations.

End-of-Life and Palliative Care

Many elderly psychiatric patients may require palliative care to manage chronic pain, distressing symptoms, and provide emotional support at the end of life.

Advanced care planning: Engaging the patient and family in discussions about treatment preferences, including Do Not Resuscitate (DNR) orders and power of attorney.

We have progressive Advanced Health Directive documentation which helps to provide a comprehensive plan as part of a patients Will and Preference.

Prevention and Early Intervention

As part of ongoing MDT processes, we provide mental health screening for a variety of comorbid disorders such as depression or cognitive decline.

Programs focused on preventing isolation, promoting healthy aging, and maintaining cognitive function through social and physical activities.

Caregiver Support and Education

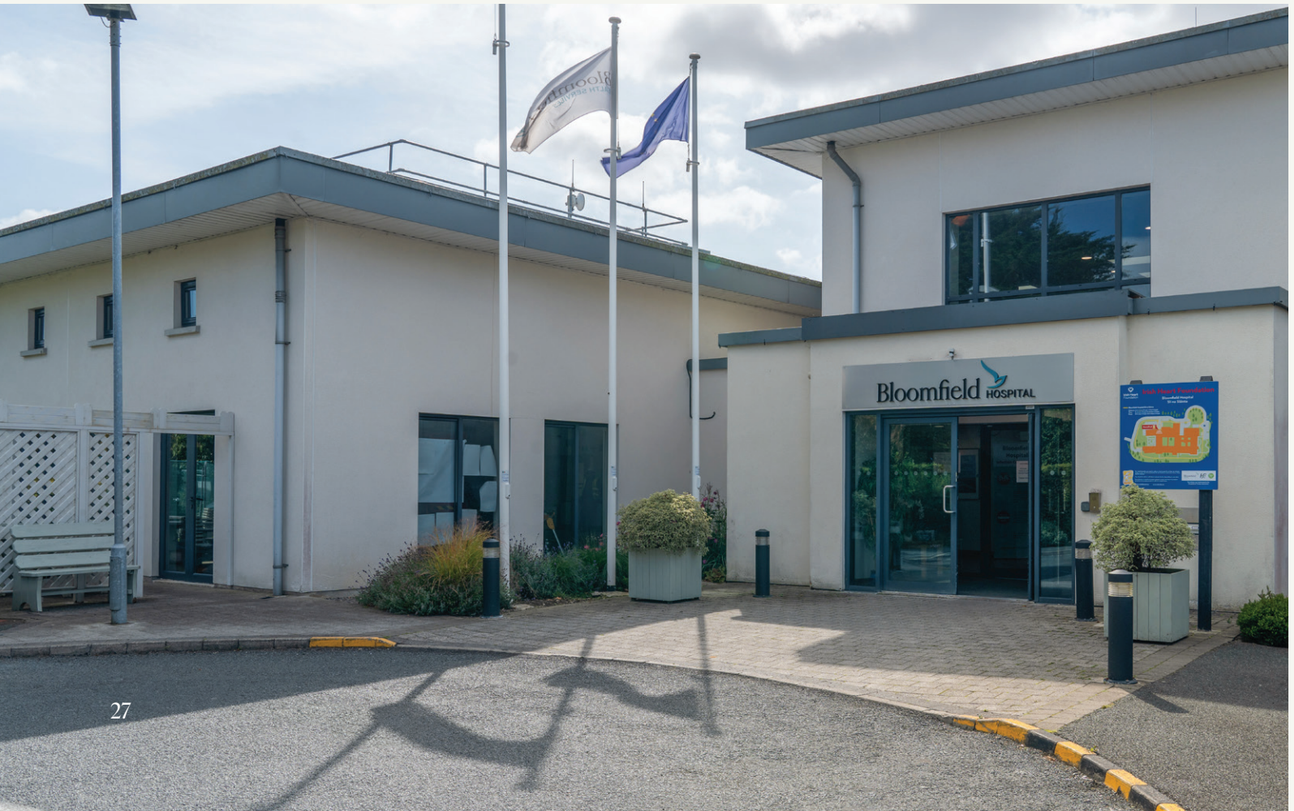
Education and training for family caregivers are vital in managing the complexities of elderly psychiatric care.

This model recognizes the intricate interplay of mental, physical, and social challenges in the elderly, offering a comprehensive, coordinated, and person-centred approach to psychiatric care in old age.

Legal Support

We provide support within existing legislation for residents. We obtain high quality legal advice from the Mental Health Act office, legal counsel and the Decision Support Service for the following areas:

- Mental Health Act 2001
- Assisted Decision Making (Capacity) Act 2015
- Decision Making Representatives
- Advanced Health Directives
- Enduring Power of Attorney
- Ward of Court
- Inherent Jurisdiction



Quality and Compliance

Bloomfield is proud to provide high quality care to our residents as a national and regional centre of excellence for neuropsychiatry and specialist rehabilitation.

Bloomfield typically aligns its policies and procedures with the HSE and other providers. This includes following consensus best practice guidance for the care of older people living with frailty.

British Geriatric Society. (2014). Fit for Frailty: Consensus best practice guidance for the care of older people living with frailty in community and outpatient settings. British Geriatric Society: London.

National Clinical Programme Older People. Specialist Geriatric Services Model of Care Part 1: Acute Service Provision.

HSE. (2015). National Clinical Programme Older People. (2015) Specialist Geriatric Team Guidance on Comprehensive Geriatric Assessment.

We follow the MHC Quality Framework for Mental Health Services in Ireland which provides a mechanism for services to continuously improve the quality of mental health services. It promotes an empowering approach to service delivery, where services facilitate an individual's personal journey towards recovery.

We continue to collaborate with academic leaders within Trinity College Dublin and University College Dublin where it comes to research and education to help improve services and to keep up with changes in the delivery of high-quality mental health services.

We also develop our programmes through co-production and consultation with advocacy groups such as the Alzheimer's Society and the Huntingdon's Disease Association of Ireland who give us regular feedback.

Notably, Bloomfield have consistently received high compliance scores from the Mental Health Commission when they inspect our premises and services.

Our team of experienced clinicians attend regional, national and international conferences networking widely to help keep up to date in advances in neuropsychiatry and the management of severe and enduring mental health issues to help make sure we get the best outcomes for our residents.

We also receive training from the Mater Lean Academy to learn how to improve and make lasting change with tangible outcomes in healthcare through their practical and accredited Lean Six Sigma in healthcare Programmes. Clinicians learn how to improve and make lasting change with tangible outcomes in healthcare through one of our practical and accredited Lean Six Sigma in healthcare Programmes. This supports us with our ongoing quality improvement programmes, audits and service evaluations where we routinely measure the quality of care provided to our residents.

Bloomfield Hospital
Stocking Lane, Rathfarnham,
Dublin 16 D16 C6T4

Tel: (01) 495 0021
Email: info@bloomfield.ie

bloomfield.ie