Integrated Patient Optimisation Program (IPOP)

survive and thrive after surgery

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Why do we do it?

- An increasing number of older patients with frailty are undergoing surgery. 30% patients presenting to the preadmission at clinic at St George age ≥ 65 had a Rockwood frailty tool ≥ 4, so there was an opportunity to intervene early to reduce the impact that the patients frailty has on there surgical episode of care
- Frailty is associated with negative outcomes (increase complications, morbidities, mortality, institutionalisation and health care costs) and quality of life.
- Frailty was not previously routinely assessed in patients undergoing surgery in New South Wales or Australia.
- Incorporating frailty assessment in the surgical pathway allows identification and early intervention and may reduce the impact of frailty.

The focus

- Assist patients to be optimally prepared for their surgical journey, to have patient centred outcomes & improve efficiency.
- **EARLY identification and intervention:** nursing interventions, Medical care, allied health.
- To reduce frailty associated risks and support health outcomes for patients undergoing surgery.
- This process optimizes the surgical journey by collating, analyzing and integrating information from multiple sources **(talking with the patient, family, GP, service providers to get a well rounded idea of how this person "does life").**
- To connect care and promote better patients' experience in an effective, safe, and positive manner.
- Develop and support patients, families, carers and health professionals to optimize shared decision making and informed consent for the patient's journey.

Integrated Outpatient Optimisation Program (IPOP)

- Started in April 2016
- Nurse led frailty screening and assessment in presurgical pathway of elective surgical patients
- 5 Surgical subspecialties (Upper Gastrointestinal, colorectal, plastics, vascular and urology patients staying overnight +)
- Comprehensive assessment and intervention
- Medical and surgical co-management with physician during inpatient
- Follow up arrangement ± outpatient clinic follow up

How it works…

- Pre-admissions (PAC) RN screens patient using Rookwood tool, referral collected by IPOP nurse , or email or phone to IPOP nurse
- Admissions clerk referral by phone or email
- GP or Surgeon, phone or email to IPOP nurse
- Patients screened by IPOP RN using the waiting for surgery list.
- Once patient consented patient can be screened by phone, in PAC, or Home visit if lives in LHD.
- Patient is registered in EMR by IPOP nurse and Comprehensive Aged Care assessment completed.
- Patient is referred to appropriate services (Pre -Surg Geriatrician consult, Staging Geriatrician, Social Worker, Dietician, Physio, Occupational Therapist MAC)
- As patient registered in EMR and alert on each IPOP patient, Patient Flow CNC emails daily report on inpatients so patients can be reviewed on ward by General Medical Physician
- Weekly MDT meeting with general Medical Physician, Dietician, S/W
- Phone call to patient post discharge, survey, check general wellbeing
- EMR letter generated to GP to discuss IPOP involvement

Outcomes

- Reduction of Length of stay 1.22 days
- Over 1100 patients screened in total. 250 patients screened in 2019. Those scoring >4 on (Rookwood tool) 121 patients had intervention.
- Increased patient and family satisfaction. Patients surveyed post discharge, commenting on the IPOP involvement as appreciated, supportive, great service, helpful and wonderful.
- 44 Cancellations of surgical procedures.
- Efficient care by front loading assessment and working closely with MDT
- Reducing fragmented medical care and upskill nursing and surgical staff.

SESLHD Aged Care Clinical Services Plan 2019-2022

The figure below highlights the potential way forward for service development in the elective surgical setting.