Improving the management of the frail elderly patient in and through the ED

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1. Aims

To improve the care and flow of frail patients through the Emergency Department (ED) and the rest of their hospital journey

To reduce length of stay and a safe return to the community when appropriate

2. Actions taken

Salisbury has an above average hospital length of stay (LOS). The frail elderly are significant in this statistic.

Our Emergency Department (ED) has always had physiotherapists (PT) and occupational therapists (OT) on its short stay emergency unit (SSEU) to aid with a rapid assessment and return home for the elderly (mainly fallers).

These patients would stay on our 8 bedded SSEU until they had been assessed by the team and then either discharged home or referred to the medical team depending on the OT/PT assessment.

Our OT/PT team formally became OPAL (Older persons assessment and liaison service) in December 2016. Mainly based in the SSEU, this team consisted of 1x OT/1x part-time PT/1x part-time specialist nurse with support and intermitted input from the Geriatricians.

The success of OPAL meant that SSEU was often full of ED patients awaiting OPAL assessment. After initial assessment, some patients benefitted from a longer stay or were awaiting beds/equipment in the community prior to discharge. These patients would remain under ED care until the day or be referred onto the medical team for further review.

This reduced SSEU flow and created a worsening bed block for ED.

There was no daily geriatrician support for the OPAL team and they received variable medical input to their comprehensive Geriatric assessment (CGA) from the ED doctors.

Ward reconfiguration

In December 2017 AMU relocated to a new ward with an assessment/ambulatory element. This was located and linked to one of the geriatric wards.

Challenges

Care staff were aware of the recent OPAL changes.

There was a rebranding opportunity to turn the geriatric ward into an acute frailty Unit (AFU).

This was an opportunistic time to move the OPAL patients into the AFU/AMU environment (and reach out into ED when needed) rather than the other way round.

Patients awaiting OPAL review were referred to the medical team and placed on the ambulatory care path or sent directly to the AFU.

We had a ‘perfect week’ to streamline the elderly patients on the AFU and to try to keep it as a 5-7 day LOS ward (in 1 week the LOS on AFU went from 14 days to 7)

Challenges

Winter pressures meant that OPAL patients were still outlying on SSEU as there were no AFU/AMU beds (but now under the medical team).

Staff shortages in nursing and consultant geriatricians meant AFU struggling with new format and skill mix of staff so direct AFU admissions dropped.

New OPAL was not based on SSEU, the community beds/community support which was being giving to them as a priority (to avoid admission- as SSEU was seen as a pre-admission ward) were being withdrawn.

Patients awaiting OPAL go to AMU or AFU (under the medical team). OPAL is now based on AFU/AMU and see outliers on SSEU and in ED.

The OPAL team now consists of 2 OT, 2 PT, 1 therapy assistant and 1 part-time specialist nurse.

Patients have improved medical reviews of their falls prior to discharge. Priority community services are attached to the OPAL team, rather than a specific ward.

3. Measures and Outcomes

We compared the number of patients seen by OPAL in 2017 to 2018 during the same 3 month period (March-June).

In 2017 228 patients were seen by OPAL. This was mainly an SSEU-based service (71.5%) with others seen on AMU (18%), directly in ED (8.5%) and other locations (8.5%). 76 patients were discharged (33%) on the same day, effectively meaning that 67% of those under ED were having to be referred onto the medical team.

With the introduction of OPAL, the average length of stay (LOS) of these patients was 4 days (compared to national average of 9.4 and hospital average of 10.8). There was a readmission rate of 11% within 60 days (hospital average 29%).

During the same period in 2018, after OPAL was moved to the AFU/AMU footprint, they saw 370 patients. 58.9% were in the new location, 24.9% on SSEU, 15.5% in ED and 0.8% in other locations. 164 (44%) were discharged home on the same day. Patient moves were fewer and OPAL was still achieving the same impact with these patients.

4. Conclusions

We have seen an improvement in patient care and LOS by looking at frailty pathways, OPAL teams and ways of streamlining services.

Frail patients have less bed moves and are being seen by the right people earlier in their hospital stay. As the OPAL team is now based on AFU/AMU they are able to see more patients and apply their expertise and resources to a wider field and so reach more patients with excellent results. (whilst still not neglecting the ED)

As well as the good clinical results that the OPAL team has achieved there has been a huge amount of positive feedback around this service from clinicians, service managers, community health and social care and importantly the patients and their relatives.

5. Lessons Learned

This is a long process and there is always something that you cannot predict e.g. staff changes, sickness.

You will never have the finished product straight away - allow for things to evolve.

Get all key stakeholders on board before initiating to make engagement easier and transition smoother.

If you try something and it is not working, know when to stop and rethink or delay & try again.

6. Potential for the future

We are developing a scoring system (looking at LOS prediction) to improve further patient flow through the hospital and direct patients onto the AFU.

A new Geriatrician is due to start work with the OPAL team. This will allow for 5/7 0900-1300 consultant input into the team, allowing for autonomous working in the mornings which can be built on in the future.