Developing Frailty Pathways

Background
We wanted to improve our pathways for frail elderly people, on the basis that: “Our philosophy is to deliver safe, compassionate care to frail adults, through encompassing holistic assessment, interventions and management of frail adults. Patients will access skilled staff and expert Geriatricians who understand the particular needs of frail adults. The care we provide needs to be just as important as the treatment we offer”. From 7th September 2016, RBCH opened an Older Persons Assessment Unit (OPAU) comprising of 25 assessment beds on ward 26 and 50 short stay beds on wards 24 and 25. The Unit offers Direct GP and Emergency Department (ED) admissions for the older person, streamlining the pathway and improving the patient journey.

Measurements

Specialty length of stay (right)
The chart on the right shows that average patient length of stay has reduced by over a day:
- 10.5 days before the project
- 9.3 days after
The opening of the Older Peoples Assessment Unit has helped further standardise the length of stay.

Number of 14d+ patients
The number of patients with a length of stay over 14 days has reduced from an average of 73.5 to 67.8 (an average reduction of 5.6 patients at any point).

Improvements
- Development of Locality Hub in Christchurch supporting care and treatment at home or closer to home
- Collaboration with other departments to develop integrated, safe and effective pathways for older people needing acute medical care
- Adopted a “Silver phone” approach whereby GP phone referrals are screened for frailty and referred to Older Persons Advanced Practitioner for triage
- Frailty Score is incorporated into Older Persons Medicine Admission Criteria
- The Older Persons Ambulatory Clinic (OPAC) providing admission avoidance for ED and GP referrals
- Sustained admission avoidance by OPAL team in ED
- Reducing Length of stay and the number of stranded patients. QI approach taken on ward 4
- Reducing numbers of outliers, supporting wards with an in-reach specialist older persons team
- Ward 24 accepting short stay patients, white board round including Social Services presence increased discharges by 15-20 per month and other short stay wards sustained their discharges
- Ward templates reviewed and adjusted to accommodate increased flow out of hours
- Successful trial and recruitment of dedicated ward team discharge planners
- Nurse consultants employed to support and structure nurse practitioners involvement in the pathway

Outcomes & Lessons Learnt
- Networking and engaging with all specialties helped gain an understanding of current ways of working and ensure communication of the project
- Consideration of how to record and measure improvement must be integral to early service development design
- The long-term impact of the pathway will ensure our patients receive a timely Comprehensive Geriatric Assessment. This is underpinned by specialist care, treatment options and pathways improving experiences of older people, their relatives and carers. Results will be presented at next year’s conference
- Close working with health and social care partners to support changes in practice is ongoing and essential

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