OPALS to FAS and Beyond

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Abstract

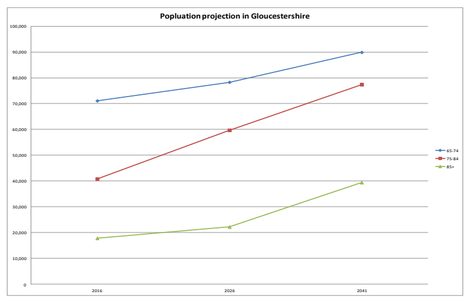
What is important to note is that our Trust has a long history of believing that a different approach is required for individuals living with frailty. The Improved Better Care Fund provided the resource to develop a comprehensive service that is now established as the Four Pillars Frailty Work Programme; a programme that looks at the individual living with frailty. The programme basically encompasses an education, an outreach, a Frailty Unit and an in reach function.

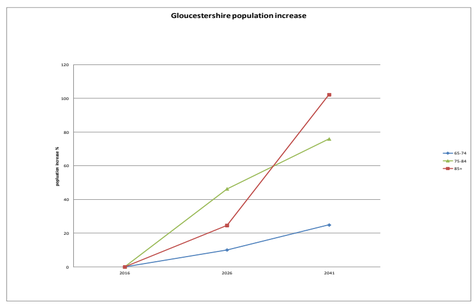
We only started formally in October 2018 but have already seen more than 550 additional patients compared with the same period last year. Our length of stay on the Frailty Assessment Unit (based on AMU) is consistently below 24 hours.

We seek to discharge as many individuals as possible (for the last five months we have discharged between 40% and 54% of all our patients) within 24hours. Furthermore when our patients do become admitted to the main hospital their LOS is on average up to two days shorter than those of the same type that were not part of the service. Going forward we will expand the service and look to see how we can work closer with our GCS colleagues in IAT as part of a 9 month pilot.

Background

In 2014, Dr Ian Donald and Teresa Clift started the Gloucestershire Older Persons Assessment and Liaison Service (OPALS). The need for specialist assessment was based on the knowledge that the population of Gloucestershire is getting older. With the number of over 85 raising by over 100% by 2041. Older patients come with their own special needs and co-morbidities.



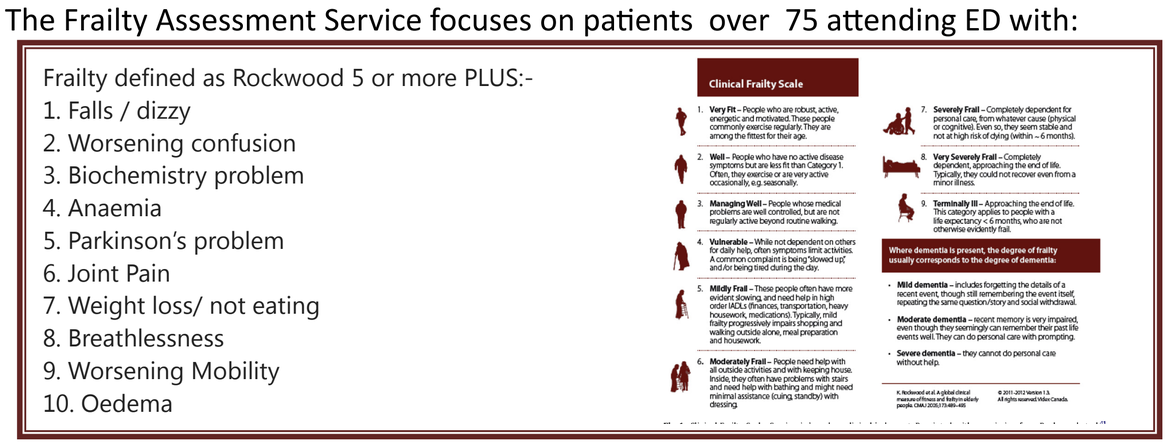


Many of the reasons that this population come into the acute hospital setting can often by managed much better in their own homes with the support of our community partners such as Complex Care @ Home and Rapid Response. OPALS and then the Frailty Assessment Team aim to help these patients ensure that they get the Right Care in the Right Place for them.

The Frailty Assessment Service focuses on patients over 75 attending ED with:

Frailty defined as Rockwood 5 or more PLUS:-

1. Falls / dizzy
2. Worsening confusion
3. Biochemistry problem
4. Anaemia
5. Parkinson's problem
6. Joint Pain
7. Weight loss/ not eating
8. Breathlessness
9. Worsening Mobility
10. Oedema



Seeing how beneficial this scheme was for patients the team grew to include additional advance nurse practitioner and nurse practitioners. Further investment, through the Improved Better Care Fund, enabled recruitment of Band 4 Frailty Co-ordinators and 8a Advanced Clinical Practitioners. This has meant that the team can see more patients, ensure that more patients get a full Comprehensive Geriatric Assessment during their visit and key conversations such as advanced care planning and Respect decisions can be started and families signposted to GP's and community Matrons to ensure that they are completed in the comfort of their own time rather than rushed during an emergency admission.

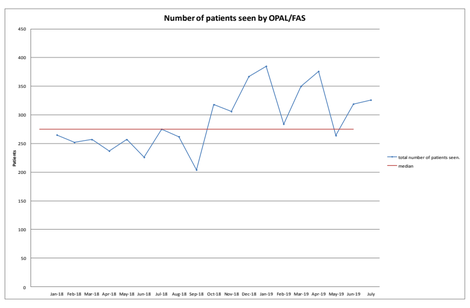
What we did next.

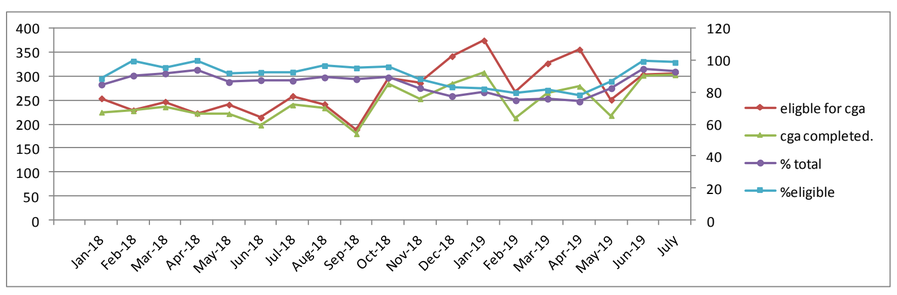
Looking at the whole pathway of patients living with frailty it was clear that the emergency admission was the middle piece of the experience. Through adopting a four pillar approach allowed us to focus on each bite size piece simultaneously with the various stakeholders. This allowed us to look at pre admission, immediate admission, step down and onward care needs of the patients.

It is clear that this work has further to go as the cohort of patients gets wider and we link in with partners cross county.

Through ulitizing 'Big Room' thinking we are able to deep dive into issues and collaborative find solutions to these to ensure that every admission has learning for the teams to ensure that he next patient has a better experience.

Results





Key results:

- Increased number of patients seen
- Increased number of CGAs completed
- Reduced length of stay (both on assessment areas and on main wards)
- Increased patient satisfaction

Learning

We are constantly learning how we can get better, improving the service. We have seen how collaborative working across specialities and without borders as part of the STP can deliver "the best care for everyone".

The Future

From October 2019, we will begin a nine month pilot looking at how we can collaborate with GCS Integrated Assessment Team and GHFT Early Supported Discharge therapy as part of the new iFAaAAS. Working together and sharing the workforce across ED, AMU, AMIA, FAU and the GRH tower block wards will ensure that we see all potentially frail patients admitted between 08:00 and 20:00.

Freeing up the appropriately skilled staff to see patients across the hospital will hopefully reduce the length of stay of all COTE patients through embracing the 'Where Best Next' methodology.