Older Persons Assessment and Liaison

Health Education England

Improving the continuity of care for people living with frailty in the acute setting

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1. The Problem

Patients living with frailty are often moved to non-speciality wards, causing a breakdown in continuity of care

People living with frailty often only requires a short admission to the hospital before being medically stable enough to return home. However, after they are admitted they are often moved around the hospital to available beds, and are therefore seen by different doctors, nurses and allied health professionals during their stay. This can lead to adverse outcomes and affect their length of stay.The OPAL team found that a lot of their patients were given an expected length of stay of less than 72 hours.

2. The Background

Ward moves and discontinuity of care increases risk of adverse outcomes and increases their length of stay in hospital

The majority of patients who are out-lied onto non-specialty wards are older people living with frailty and those who have cognitive impairments (BGS, 2014). Multiple ward moves in this group of patients can lead to susceptibility to delirium and effects of polypharmacy, an increased risk of falls, serious injuries and death. Ward moves and outlying patients are often seen as an unavoidable event, considering the increasing demands on the NHS.

3. The Project

OPAL in-reach service will maintain continuity of care regardless of which ward the patient goes to

The Older Persons Assessment and Liaison (OPAL) team works within the Emergency Department and Acute Medical Unit to identify those people living with frailty and ensure they receive comprehensive specialist assessment in line with current national guidance.

The process:

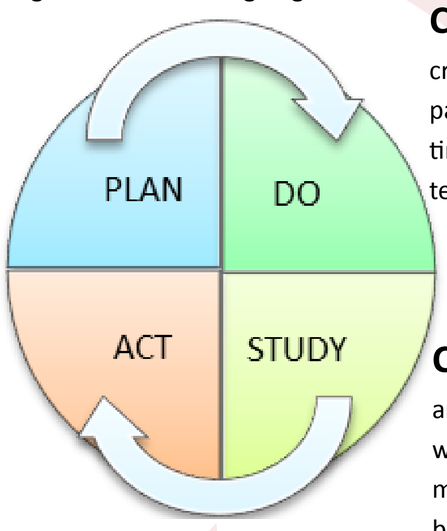
- All new admissions during OPAL working hours were screened for frailty syndromes and their EDD and assessed by the OPAL team.
- The following day in-reach patients continued to be seen by the OPAL team, regardless of which ward they had moved to.
- If a patient's medical needs changed and their length EDD was expected to be over 72 hours, they were handed over to the ward based teams for ongoing input.

4. Aim:

To increase the number of OPAL patients with an EDD of 72 hours discharged within that time to 60% by December 2018

5. Plan Do Study Act

Cycle 1: Inclusion criteria was agreed following a several planning meetings, 17 patients in-reached with great success, regular reviews of ongoing cases.

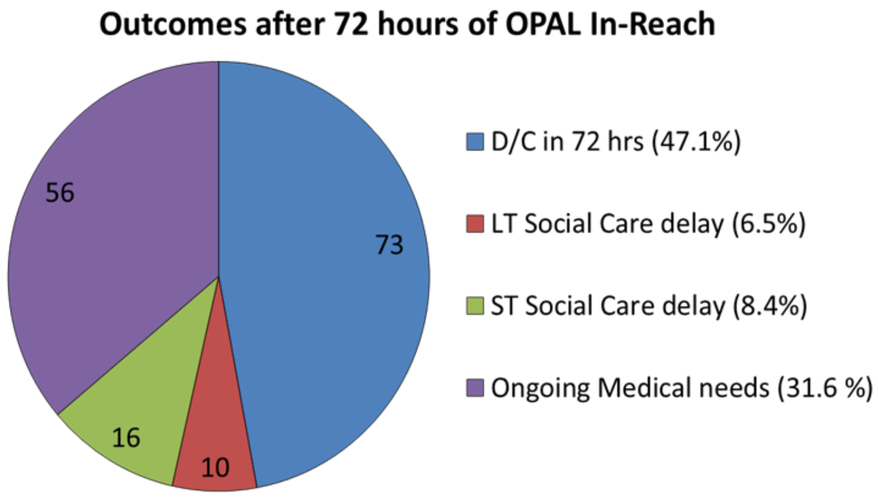


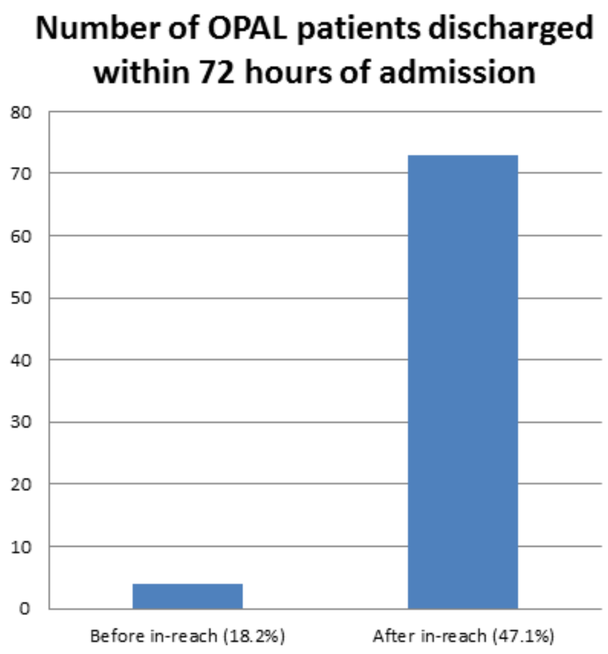
Cycle 2: We widened our inclusion criteria but found that we selected patients who ended up staying for a long time, or had to hand over to the ward team, thus decreasing continuity of care

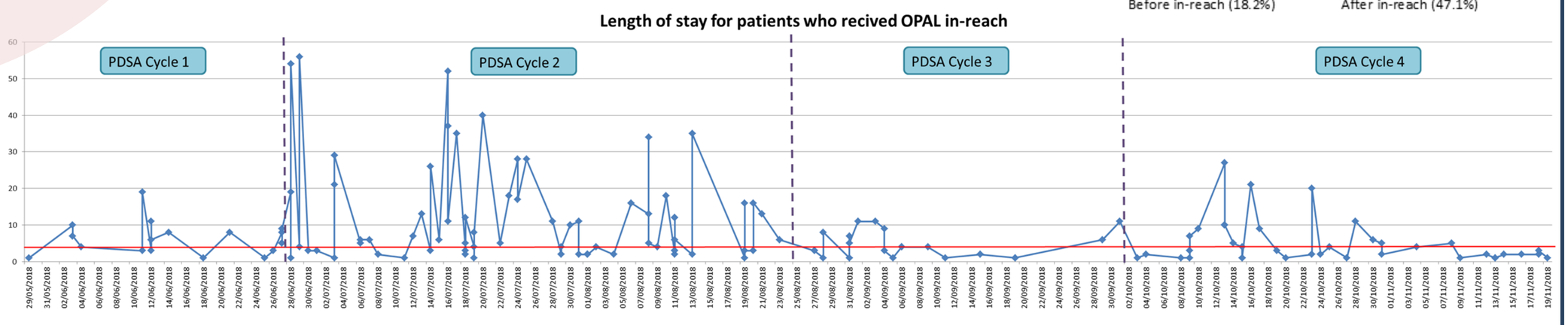
Cycle 3: We reassessed our capacity and inclusion criteria but we found that we were seeing less patients and the we may be missing some patients who could benefit from our input

Cycle 4: Strict inclusion criteria was agreed. Twice daily team huddles were introduced as well as increased support from Geriatricians to set EDDs

6. Results







The numbers:

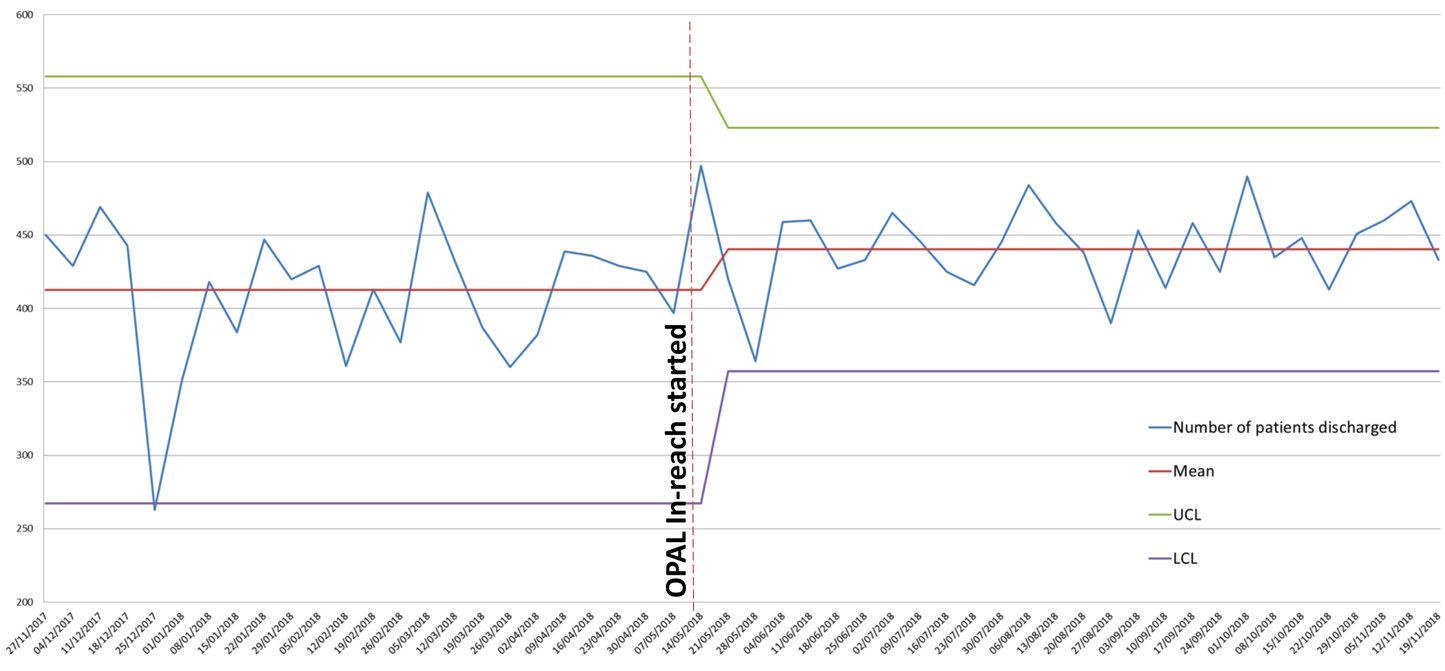
- 5 WTE OPAL team members
- 674 patients seen by OPAL service
- 155 patients received in-reach service over 7 months
- 73 patients discharged within 72 hours of admission

The successes:

- The implementation of the OPAL in-reach service increased the number of patients discharged within 72 hours (whole hospital impact)
- Average length of stay reduced from 10.3 to 8.5 days
- Prior to OPAL in-reach: **18.2%** of OPAL patients with an EDD of 72 hours discharged within that time.
- After OPAL in-reach: **47.1%** of OPAL patients discharged within 72 hours

The barriers:

- 49/142 Ongoing medical needs - OPAL was unable to have consistent geriatrician input
- 23/142 Long or short term community care was not available - OPAL was unable to transfer care of medically fit patients due to the capacity of community services



7. Conclusion

The OPAL Team was able to increase the number of older patients, living with frailty, that were discharged within 72 hours of admission by in-reaching onto wards and providing continuity of care. The capacity of the OPAL team has been impacted to complete this project which has reduced the number of patients which could be seen at the front door. It is now necessary to consider the future of the in-reach program. This will include further PDSA cycles to assess if implementing an increased medical approach to in-reach will increase the number of patients discharged within 72 hours. It will also require the completion of a business case to increase the current staffing establishment to ensure the in-reach service is consistent and equitable.

Continuity of care contributed to patients living with frailty achieving their EDD

Would OPAL need to in-reach if there was an Acute Frailty Unit?

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