# Frail Older Persons Pathway

**Background/context**

NHS Ayrshire and Arran has had some challenging targets to achieve in respect of A&E 4 hour waits, the number of admissions and bed day rates for those aged 75+, the number of days lost to delayed discharge and the number of comprehensive geriatric assessment completed.

It has become evident that in order to meet the demands of the demographic rise in older people with complex physical and mental health issues there is a need to change the way in which we deliver services. In response to these demands there has been a greater emphasis in Older People’s Services the Intermediate Care & Enablement Service (IC&ES) on developing new models of care that provide an alternative to hospital admission and which support an anticipatory and early intervention approach.

While further development of community services is crucial to stemming the flow of admissions to hospital there is also a need for services within the acute sector to be redesigned. The development of new models of assessment and pathways that meet the particular needs of frail elderly patients is essential to help prevent admission and promote early discharge.

**Problem**

Maintaining hospital flow and achieving Emergency Department (ED) attendance and admission targets continues to present a significant challenge for NHS Ayrshire and Arran and which has a negative impact on achieving quality outcomes for older people.

The demographic change in Ayrshire and people utilising ED as a primary care assessment, along with an increase in frailty and co-
morbidity has resulted in increased pressure on our acute hospital systems.

**Aim**

- Early identification of frailty
- Improve admission to senior medical review time
- Improve admission to specialist GCA start time
- Early identification of delirium
- Provide person-centred care
- Decrease unplanned admissions
- Not adversely affect 4 hour wait times

To design a system around frail older people presenting to acute hospital and not expect them to adapt to a system that does not meet their needs

**Action taken**

From 16 September 2013 a Frail Older People Pathway (Appendix 1) was established to assess those aged 65 and over who attended the ED at Crosshouse Hospital between the hours of 9am – 5pm, Monday to Friday. The pilot uses a frailty score (see appendix 2) to identify those patients who require a specialist assessment by a Consultant Geriatrician and multi-disciplinary team to prevent an avoidable hospital admission. This specialist assessment also ensures that if patients have to be admitted they receive the right care and treatment at the right time and are discharged at the earliest opportunity.

The core team consists of a Consultant Geriatrician, *IC&ES Practitioner, Community Psychiatric Nurse (Elderly Mental Health Liaison), Pharmacist, Advanced Nurse Practitioner, Administrator, and ICES Physiotherapist.*

(*IC&ES Community Assessment and Rehabilitation Nurse or Occupational Therapist)

The core team collates background information on the person’s normal health, social and environmental status. They complete a comprehensive geriatric assessment which considers medical, physical, functional, mental, and pharmacological and any other...
issues that compromise the patient’s ability to cope at home. IC&ES practitioners then liaise with a range of statutory, independent and voluntary sector community based services to enable discharge home.

The team is based within the ED with a pathway to the Clinical Decisions Unit (CDU) and Older Persons short stay beds within Care of the Elderly wards.

<table>
<thead>
<tr>
<th>Results</th>
<th>University Hospital Crosshouse</th>
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<tbody>
<tr>
<td></td>
<td>The Crosshouse data now available indicates that both quantitatively and qualitatively, the pilot has had a positive impact on patients, staff and the general functioning of the hospital during the pilot hours.</td>
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<td>The time to first consultation and assessment by the Consultant Geriatrician and core team has consistently been carried out in just over one hour from initial ED triage. This allows a prompt decision to be made regarding the need for admission or discharge home with the appropriate follow up.</td>
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<td>This prompt decision-making has resulted in an 8 per cent reduction in the admission rate.</td>
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<td>The table below shows the number of patients that the core team has assessed, the numbers discharged home and the bed days saved. The figures show that on average 42 per cent of patients assessed by the Frail Elderly Team, who would otherwise have been admitted were able to be discharged.</td>
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### FRAIL OLDER PERSON PATHWAY - CROSSHOUSE HOSPITAL

<table>
<thead>
<tr>
<th>Crosshouse 16/09/2013 – 31/05/2014</th>
<th>TOTAL</th>
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<tbody>
<tr>
<td>Total patients &gt;64 of age presenting at ED between 9am - 5pm</td>
<td>3,989</td>
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<td>Number suitable for the pilot</td>
<td>1,194</td>
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<td>Patients discharged home who were part of pilot</td>
<td>465</td>
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<tr>
<td><strong>Total Bed Days Saved</strong> (based on an average LoS of 5 days)</td>
<td><strong>2,325</strong></td>
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As shown in Appendix 3 the pilot is having a positive impact on the 4 hour ED standard and has also contributed to a reduction in the number of 8 and 12 hour trolley waits.

Early indications also show that the mean length of stay for patients on the pathway who required admission was reduced from 6 days to 4 days (see Appendix 4). Patients were also less likely to be re-admitted and mortality rates appeared to have improved (see Appendix 5).

It has been noted that the early assessment has created a more varied discharge destination from ED with less people having to go to the medical receiving unit.

During the pilot staff, patients and relatives were also asked about their experience. Their feedback was overwhelmingly positive and a sample of their responses is shown in Appendix 6.

<table>
<thead>
<tr>
<th>Efficiency savings and productive gains</th>
<th>See results</th>
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<tr>
<td><strong>Sustainability</strong></td>
<td>A business case is currently being prepared for corporate management team to consider the next steps.</td>
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<td>Lessons learned</td>
<td>At this early stage strong evidence this approach is beneficial for both the person and the organisation. Action groups have been set up to imbed the process into our ED departments and plan a full implementation in our proposed combined assessment units.</td>
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Appendix 1

**FRAIL OLDER PERSONS PATHWAY**

- Patient arrives at Emergency Department
- Triage Nurse Emergency Dept
- 2nd Practitioner Review Emergency Dept
- MDT Meeting
- Biggart Central Ayrshire Central Hospital
- CDU/OBS Ward
- Older Persons Short Stay Bed (72 Hours)
- Station 7/Ward 3E
- Community Hospital
- Step Down Bed
- Home
- In Patient Bed
Appendix 2

FRAIL INDEX SCORE

<table>
<thead>
<tr>
<th>Frailty Criteria &gt;65 years of age with 1 or more below</th>
<th>Please tick</th>
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<tbody>
<tr>
<td>Residential or nursing home resident</td>
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<tr>
<td>Delirium (4AT)</td>
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<td>Dementia</td>
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<td>Impaired mobility or other functional impairment</td>
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<td>Fall in past month</td>
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<td>Incontinence</td>
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<td>Care Package</td>
<td></td>
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<td>MEWS&gt;3</td>
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Exclusion:

troponin positive chest pain, stroke, need for HDU, ITU or CCU level care, renal dialysis patients, clear need for other specialty care
Appendix 4

Frail Older Person Pathway Pilot - Control Group
LoS of ED Admissions ≥ 65YOA
Admitted 1st - 7th April 2013 (Reviewed 1st Aug 2013)

Frail Older Person Pathway Pilot
LoS of All ED Admissions ≥ 65YOA
Admitted 13th - 17th May 2013 (Reviewed 1st Aug 2013)
Appendix 5

Readmission and Mortality Percentage of FOPP versus control

- <7 days
- 8-28 days
- >28 days
- Discharge
- Died

%FOPP
%Control
Appendix 6

Staff, patients and relatives enthused by the effect of the service

- Early contact with families, invaluable
- Some people don't like change but no one can argue with the success of this pilot home
- Amazing! Revolutionized the service!

- Impressed with how quickly patients were turned around
- This has been good—how can it be mainstreamed to give a better service
- It seems to have been safely discharged in a shorter period of time

- It felt like we weren't as busy but I wonder if it was actually that the throughput was simply better
- We hope that my father didn't need to be admitted
- I thought that my mum would still be kept in but she is happy to be getting home

- This has to be better for patients, going home with the support that they need rather than being admitted
- What is going to happen to make this mainstreamed, it would be such a shame to lose it all now

- I didn't want to come in but glad that it was just oversight
- This has been good but will seem worse next week when we go back to normal