Reaching for the summit....

Older People Short Stay Unit (OPSSU) team working across emergency areas reduces length of stay (LOS) in the over 75s
Content

• The humble beginnings
• OPSSU model
• OPSSU impact
• Road to fruition
Humble beginnings – Older Persons Assessment and Liaison Service (OPAL)

The goal was to improve the quality of care provided in hospital for over 75, frail elderly patients with complex conditions.

Dedicated team: Senior Nurse, Therapists, Pharmacist and Dietician covering a 7 day service.

Initial CGA’s identified by Frailty Triggers.

Assessments completed by OPAL Therapist/Nurse.

Evolution to a (novel) OPPSU Model

- Engagement meetings with patients, GPs and community partners (Aug 2015)
- Amalgamate the existing OPAL team with the acute therapy team (Oct 2015)
- Standardised Integrated frailty assessment document (Oct 2015)
- Senior therapy presence in emergency areas (Nov 2015)
- Frailty Unit (OPPSU) on Cherry Ward established (Dec 2015)
- Initially 13 beds, expanded to 20 beds (Aug 16) then 29 beds (Oct 16)
- Employed 2\textsuperscript{nd} geriatrician with expansion to 29 bedded OPSSU (Oct 2016)
Clinical Frailty Scale

1. **Very Fit** – People who are robust, active, energetic and motivated. These people commonly exercise regularly. They are among the fittest for their age.

2. **Well** – People who have no active disease symptoms but are less fit than Category 1. Often, they exercise or are very active occasionally, e.g. seasonally.

3. **Managing Well** – People whose medical problems are well controlled, but are not regularly active beyond routine walking.

4. **Vulnerable** – While not dependent on others for daily help, often symptoms limit activities. A common complaint is being “slowed up,” and/or being tired during the day.

5. **Mildly Frail** – These people often have more evident slowing, and need help in high order IADLs (finances, transportation, heavy housework, medications). Typically, mild frailty progressively impairs shopping and walking outside alone, meal preparation and housework.

6. **Moderately Frail** – People need help with all outside activities and with keeping house. Inside, they often have problems with stairs and need help with bathing and might need minimal assistance (cuing, standby) with dressing.

7. **Severely Frail** – Completely dependent for personal care, from whatever cause (physical or cognitive). Even so, they seem stable and not at high risk of dying (within ~ 6 months).

8. **Very Severely Frail** – Completely dependent, approaching the end of life. Typically, they could not recover even from a minor illness.

9. **Terminal Ill** – Approaching the end of life. This category applies to people with a life expectancy < 6 months, who are not otherwise evidently frail.

Where dementia is present, the degree of frailty usually corresponds to the degree of dementia:

- **Mild dementia** – includes forgetting the details of a recent event, though still remembering the event itself, repeating the same question/story and social withdrawal.

- **Moderate dementia** – recent memory is very impaired, even though they seemingly can remember their past life events well. They can do personal care with prompting.

- **Severe dementia** – they cannot do personal care without help.
Welcome to Cherry Ward

We can provide interpreters for a variety of languages, information in larger print or other formats (e.g. audio) - please call us on 01932 723553.
To use the Text Relay service, prefix all numbers with 18001.

Ashford Hospital
London Road
Ashford, Middlesex
TW15 3AA
Tel: 01784 884486
Website: www.ashfordstpeters.nhs.uk

St. Peter’s Hospital
Guildford Road
Chertsey, Surrey
KT16 0PZ
Tel: 01932 872000

Patients first • Personal responsibility • Passion for excellence • Pride in our team
PREVENTING DECONDITIONING AND ENABLING INDEPENDENCE FOR OLDER PEOPLE IN HOSPITAL

Older people in hospital can be more at risk of:
- Reduced bone mass and muscle strength
- Problems with blood pressure control
- Reduced mobility
- Confusion due to changes in environment
- Demotivation

When an older person comes to hospital...

... and lies in bed, it can affect their wellbeing and physical function

THIS IS KNOWN AS ‘DECONDITIONING’

Increased risk of falls due to muscle weakness
Increased confusion or disorientation
Further immobility due to inactivity

Constipation and incontinence
Lying in bed can affect appetite and digestion
Increased risk of swallowing problems leading to pneumonia

This is often made worse by multiple medications, sensory impairment, dementia and current illness

Comprehensive Geriatric Assessment
A risk assessment should be completed to determine normal capabilities
Glasses and hearing aids should be accessible

A Comprehensive Assessment should be completed to determine normal capabilities

Support
Are there appropriate mobility aids available
Walking to the toilet helps to prepare for going home
Sitting out of bed helps (when possible)

Encourage
Feed or take fluids independently
Wash and dress independently
Keep moving arms and legs even in a bed or chair

Thinking about how to support and encourage movement helps to:
- Reduce the risk of harm from falls, infection, clots and delirium
- Reduce the potential of harm from pressure ulcers
- Reduce the length of stay in hospital
- Reduce the likelihood of having an increase in future care needs

Sit up... Get dressed... Keep moving...

YOUR MUSCLES / YOUR STRENGTH / YOUR ABILITIES - USE THEM OR LOSE THEM
Who do we interact with

- GPs
- Specialists
- Locality Hub (MDT led community service)
- Other community services – social, mental health, palliative care, diabetes, district nurses, care homes
- We are contactable through a bleep, switchboard or directly to the ward

STRONGLY VALUE PARTNERSHIP AND FRIENDSHIP WITH COMMUNITY SERVICES – INTERGRATED CARE PLANS / PATHWAYS
LOS for the over 75s

Before OPAL April 12 - March 13 - LOS 9.14
OPAL April 14 - March 15 – LOS 8.9

13.4% reduction in LOS
LOS for the under 75

6.6% reduction in LOS
12 month since the frailty unit opened
LOS for over 75

<table>
<thead>
<tr>
<th>Year</th>
<th>OPAL</th>
<th>Part OPSSU</th>
<th>OPSSU</th>
</tr>
</thead>
<tbody>
<tr>
<td>2014-15</td>
<td>8.90</td>
<td>8.17</td>
<td>7.72</td>
</tr>
</tbody>
</table>

Patients first • Personal responsibility • Passion for excellence • Pride in our team
NHS Benchmarking Audit

April 15-March 16
Age 75 – 84: 7.7 days 13th (NA 8.9 days)
Age over 85: 8.5 days 9th (NA 11.1 days)

April 14 – March 15
Age 75 – 84: 8.6 days 25th (NA 8.4 days)
Age over 85: 9.5 days 17th (NA 10.1 days)
OPSSU Impact (Dec 15 – Apr 17)

- The unit has seen over 2,055 patients since opening (now averaging 160/month)

- Over 7,650 patients seen by OPSSU team (A&E, CDU, AMU, frailty unit)

- Average LOS in unit 4.32 days
Road to fruition. Future Model

• Re-introduction of dedicated specialist nurse, pharmacist and dietician and speech and language therapist
• Extending the team to provide front door triage service linking directly into OPSSU – liaison with ED, ambulance service
• Integrated working with Adult Social Care, community partners and voluntary organisation – D2A, Locality Hubs, GPs and so on
• Progression of team to provide identified immediate “discharge” needs - evolution of a discharge facilitator role
• Frailty practitioner role embedded in daily clinical assessments and activities
• Consideration of a nutrition and well being champion or practitioner
Questions please.....