Royal Berkshire NHS Foundation Trust and Acute Frailty

Background

The Royal Berkshire NHS Foundation Trust (RBFT) has a history of good services for older people and joined the Acute Frailty Network in January 2015 to share best practice and further develop, discuss and share with others the solutions to the Acute Frailty Patient issues.

Our Trust’s aim is:

“To provide the best healthcare in the UK for our patients in our community”.

RBFT is an acute general hospital serving a community of approximately 500,000 patients in Berkshire and South Oxfordshire, residing mainly in five different unitary authorities (Reading, West Berkshire, Wokingham, South Oxfordshire and Bracknell).

On average, 1200 patients aged over 75 years, attend our Emergency Department every month. We have 130 Elderly Care beds across 5 wards, and we see between 20 to 40 new older people admissions each twenty-four hour period.

In our over 75 year patient pathway, we have worked with our local GPs to determine a swift senior response to the need for a patient to see the RBH medical team. GPs have direct access to the Consultant on call (the Elderly Care Physician of the Day: ECPOD) and can call to receive advice. They may be asked to send the patient to the Emergency Department if they are actually unwell or more often, straight to the GP Admissions Unit where an Elderly Care Consultant can see the patient 8-8, 7 days a week.
Established Acute Frailty Service:

The pathway above details the previously established admission process for patients aged over 75 years presenting to hospital as an emergency. Below each element of the service for older people at RBFT is described;

Acute Medical Unit

RBFT has a combined Acute Medical Unit (AMU) of 34 beds rather than a separate frailty unit. These beds include 6 side rooms and a 4-bedded Higher Monitoring Unit (HMU). We have Geriatricians closely working alongside Acute Physicians with a joint MDT board round at the end of the morning. At this meeting, all the patients on the unit are discussed; discharges are clarified, predicted length of stay determined, and allocation to appropriate wards determined. It is felt that the patients and staff benefit from this shared working environment and learn from each other’s expertise and knowledge. This was the main driver in the decision not to have a separate ‘Frailty Unit’. AMU has a dedicated Pharmacy team providing an excellent medicine reconciliation service, which has recently extended into the Short Stay Unit (SSU) and the ED Observation Ward.

The Medical Team

The Elderly Care Consultants work together as a strong, dedicated team and are “extremely proud” of the Elderly Care Physician of the Day (ECPOD) service, which allows us to see all new older people admissions promptly. With a Geriatrician on site, new admissions are seen from 8am - 8pm seven days a week. We are able to provide this level of service due to having 10 Consultants on the rota. When the ECPOD service started approximately 10 years ago there were only 4 Consultant Geriatricians, and the service was
provided only Monday to Friday 9-5. As consultant numbers have increased, so has our coverage. We now also provide consultant cover to our Elderly Care wards at weekends.

**Therapy Services**

Our Occupational Therapy team at the ‘front-door’ (ED OT Team) see between 10-18 patients daily in ED and AMU, and facilitate 200 avoided admissions per month. They provide an excellent 7 day service from 9am to 9pm, and work closely alongside the ECPOD and Interface Geriatricians.

Staff feel they are:

“**Instrumental in facilitating patient flow by ensuring patients reach an appropriate destination from the patient perspective - most patients do not wish to be admitted to hospital and the EDOT work with the patients to avoid this outcome wherever possible.**”

They also feel that the “**excellent working relationship they have with the MDT is based on mutual respect of each other’s skills and knowledge**”.

**Emergency Department**

Our Emergency Department Observation Bay (ED Obs) has recently been upgraded to create 8 beds and a seated assessment area. This area is intended for medically stable patients who are expected to return home within 12 hours. We have been working hard to identify frail older people who are best suited for this area. It is felt that patients awaiting therapy assessment or a specific further investigation are most appropriate.

**GP Admissions Unit**

At the beginning of 2015 a new GP Admissions Unit (GPU) opened, located alongside AMU with the intention of relieving pressure on ED by creating a dual point of entry. Admission referrals from the
community are to be diverted to this unit - unless patients are so acutely unwell as to require admission via the Resuscitation Department in ED (which would also apply to acute stroke patients requiring an assessment of suitability for thrombolysis). This unit has an ambulatory area staffed with ANPs who see, treat and discharge patients working alongside the Geriatricians across specific pathways including the DVT clinic, as well as a 9-bedded area for less mobile or unwell patients. Patients are assessed, clerked, have their initial investigations and treatment here before being reviewed by the appropriate consultant (Acute Medicine or Elderly Care). From here, patients are transferred to an appropriate ward or discharged home.

**Interface Geriatric Service**

RBFT has had an Interface Geriatric Service since October 2013. This provides Consultant Geriatrician input to patients at the front door, mainly based on AMU but also working on the Short Stay Unit situated next door, and providing expertise to the ED Obs bay when requested. The main role of the Interface Geriatrician is to care for the elderly care patients who have previously been admitted but remain on AMU, i.e. those seen by the ECPOD on previous days. They establish the diagnosis, compete the Comprehensive Geriatric Assessment (CGA), (re)set EDD, establish clinical criteria for discharge, facilitate discharge planning, signpost and liaise with community teams/services/geriatricians, and perform advanced care planning amongst other things!

**Short Stay**

A new Short Stay Unit (SSU) has opened, again situated alongside the AMU. This has 22 beds and is designed to cater for both adult medicine and elderly care patients who are expected to be discharged within 48-72 hours. This also had dedicated pharmacy support and seven day senior doctor and therapy input.

**Social Care**

Social care packages are held open for patients whilst they remain on AMU for up to 48 hours, with hopes to extend this to 72 hours and to include hour SSU. This facilitates a swift return home once the discharge decision has been reached.

**In-patient Wards**

RBFT has five dedicated elderly care wards. This includes two acute female wards, one acute male ward, one orthogeriatrics ward, and a post-acute ward with emphasis on rehabilitation and discharge planning. All of these wards have daily MDT board rounds and regular consultant ward rounds (2-3 times a week). There are enhanced recovery procedures and paperwork in place and all wards have been refurbished to be dementia friendly.

**Orthogeriatric Service**

The Comprehensive Orthogeriatric Service started in August 2007, providing daily input on the orthopaedic
wards with pre-operative assessment and multidisciplinary rehabilitation. Some patients with fragility fractures were transferred to Elderly Care for ongoing rehabilitation on a small orthogeriatric ward. This ward increased from 12 to 28 beds at the start of 2015 and is now admitted patients directly from ED in order to provide the perioperative care as well as multidisciplinary input and rehabilitation. This has facilitated an excellent pathway for hip-fracture patients.

**Surgical Liaison**

A Surgical Liaison Service commenced in 2013, comprised of medial assessment for predominantly emergency admissions over the age of 70 years, with some input to planned surgical admissions. Now all emergency admissions of patients over 70 years are reviewed by a Geriatrician. There is also routine daily Geriatrician input available for all emergency laparotomy patients as suggested in the National Emergency Laparotomy Audit. We also have a successful Comprehensive Care of the Older Patient with Cancer (COCOC) Service which links into the Surgical Liaison Service.

Supporting all of our services the RBFT Service Navigation Team work closely with acute and community services to ensure that patients receive care in the most appropriate environment following the acute phase of their illness. The team provides support for the entirety of an inpatient stay, from joining the ECPod post-take ward round, to caring for the patient in the discharge lounge. They liaise with community teams on admission to expedite discharges in those well enough to go home promptly, and also coordinate discharge with particular emphasis on those in hospital the longest and with most complex needs.

We also have three Community Geriatricians working across our three nearest unitary authorities (Reading, Wokingham and West Berks). As well as providing daily input into their local community hospital, their other roles include conducting a rapid access clinic, close working with community matrons and local intermediate care services, domiciliary services and in-reach to residential and nursing homes.

**Improving the Environment for People with Dementia**

Following a bid put together by one of our Elderly Care Consultants, in June 2013 we were awarded almost £0.5m in funding from the Department of Health to improve our ward environments for patients with Dementia.

The project involved four of our elderly care wards as we deliberately wished to steer away from a dedicated dementia ward. Staff felt strongly that the ethos of creating a dementia friendly community would be lost by confining the improvements to just one ward.
The concept for the design was:

Colour coding the ‘themed’ bed bays making each patient’s bed space easier to identify

Improving signs

Coloured grab rails and toilet seats to promote continence

Replacement of the speckled shiny floor with a plain, matt surface (some patients were afraid to mobilise as they felt they might slip)

Reduction of the size of the nursing stations and the introduction of areas within the bays for nurses to work, facilitating more staff in the bays to help with monitoring patients who are at risk of falls and aiding communication with families

Creation of a social area for patients to participate in activities

The dayrooms continued to have an area for social dining but in addition they will each have a specialist use

Creation of an area in one day room with patients can sit at any time and access objects to stimulate conversation and memories (extending the scope of our weekly reminiscence group)

Creation of a sensory area to create a calming environment
Creation of a cinema room to relax patients (an idea sparked by the benefits we saw when patients watched the Olympics together)

Recent Developments

Over the past year we have reviewed and further improved our services by introducing a dual point of entry with new GP Admissions Unit, including ambulatory assessment area.

Undertaken ward reconfiguration resulting in our Short Stay Unit (mixed adult medicine and elderly care), along side Acute Medical Unit and new enlarged orthogeriatric unit (now 28 beds from 12) and opened a new Rapid Access for the Older Patient (RACOP) clinic located at ground level where access is much improved.

Planned Services

We are working on;

- A new referral route for RACOP - a fax referral system was introduced several years ago in an attempt to expedite referrals. There are still delays ad a recent audit revealed that efficiency of the service
could be significantly improved if access was made easier and more efficient. We are currently communicating with our local GPs, and are introducing a telephone referral system with direct access to a Geriatrician via a bleep

- A new advice and guidance service for ED doctors regarding identification and management of frailty, RACOP and Falls services

- Telephone access to Geriatrician for GP and ED - we plan to use a bleep for this due to mobile phone signal being very poor in ED and AMU

- We have previously been able to perform regular liaison (OPAL) ward rounds on Cardiology, Respiratory and Gastroenterology wards (this is not all of our medical wards). Two of our colleagues are currently on maternity leave and we have been unable to appoint sufficient maternity locums to support this service. We plan to restart this in the near future

Issues and Stumbling Blocks

- As stated above, the new ED Obs ward find it difficult to select appropriate patients, i.e. those that are most likely to be discharged the following day. How have other areas approached this issue? As present, approximately 20% of ED Obs patients are then subsequently admitted. We are uncertain whether this confirms that the correct patients are utilising the beds there

- We would like all potentially frail patients to have a cognitive assessment performed and documented but the engagement with this has been poor

- There are delays in accessing the RACOP clinic; related to referral and access. We have capacity to see more patients. Often patients are admitted before they can be seen. We are hoping this can be addressed with our planned new referral system

- Short stay patients - identification of appropriate patients continues to prove challenging as does ensuring their care packages are kept open. Availability of carers in the local area is limited. This prevents local authorities keeping care packages open for longer than 48-72 hours. Some patients who are transferred to SSU require a much longer admission than we expect, but predicting these patients is very difficult.

We hope this provides an insight into our previous, current and future plans for patients with Acute Frailty in the Royal Berkshire NHS Foundation Trust.

We welcome colleagues who would like to visit the hospital and see our services, especially if they provide advice and feedback about their own difficulties!

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