Improving Acute Care and discharge planning for older people with frailty

Guy’s and St Thomas

Karen Titchener MSc RGN Deputy Head of Nursing

Dr Rebekah Schiff Clinical Lead, Dept Ageing and Health

Bringing hospital care to your home
@home Introduction

• @home is an integrated “Hospital in the Home” service for patients living in Lambeth and Southwark over the age of 18 who would otherwise be or be at risk of a hospital admission
• provides acute healthcare at home
• supports early discharge from hospital
• prevents avoidable admissions, readmissions
• saves valuable hospital bed days
• reduces length of stay (LOS)
• Provides overnight palliative care for EOL patients
Bringing Care Closer To Home

@home is a bespoke and evolutionary Multidisciplinary team OFFERING

- Patient centred acute care in their place of residence
- Practitioner to practitioner referral via single point access
- 2 hour response for urgent medical assessment
- Shared or total medical responsibility for patient
- Team operates 365 days of the year 24 hours as day
- Domilicary visits by consultant or @home GP when required
- Provide daily visits up to 4 times a day for 3-7 days
- Intensive Nursing, PT,OT input during intervention
- EOL care with overnight support
@home look after patents with conditions including

- Falls
- Chronic Obstructive Pulmonary Disease
- Unstable Diabetes
- Dehydration
- Palliative Care
- Gastroenteritis
- Community Acquired Pneumonia
- Heart Failure
- Renal failure
- Deep Vein Thrombosis
- Infected Foot Ulcers
- Post-operative surgery
- Urinary Tract Infection
- Viral Illness
Pal@home

• New extension to @home providing:

• a rapid response ‘out of hours’ urgent/crisis nursing care service providing prompt clinical support and nursing care at short notice, through proactive visits, or in response to an unscheduled request.

• for patients who are identified as End of Life, are nearing death or require palliative or @home OOH support and who meet the service referral criteria
Integrated Partners

- Social Care
- GSTT & KCH
- Community MDM
- Delirium
- Rehab Services
- District Nursing
- SLAM
- GP
- Learning Disabilities
- Heart Failure
- LAS
- Palliative Care
- Obs & Gynae
- Pharmacy
- Care Home

Patient @home
Older persons’ pathway
Integrating care across community and hospital at GSTT

GP & Community
Local care networks

Early medical/ functional decline
GP support via TALK/ community MDTM/ virtual clinics

Acutely unwell
Paramedics
Community GP

Medical diagnosis/treatment
(point of care testing)
Functional support and rehab

Acute @home
(GSTT@home and ERR)

TALK

OPAU
Diagnostics required and specialist opinion

Hospital

Acute OPU

OPU

D2A

Transport

Functional dependency too high to remain at home

Community beds - PULROSS

Functional dependency too high to remain at home
- Lack of direct access to specialist
- so with no extra resource
- 24/7 direct access Geriatrician or next day appointment line
- Half calls result in urgent OPAU appointment
- Used by GPs, other community staff and a few patients
A and E traditional pathway

- older adult average 3hrs 49 minutes A and E stay
- Older adults attending A & E are more likely to be admitted than comparative younger adults
- Once admitted older adults stay in hospital longer than younger adults
- Admission associated with adverse outcomes; delirium, hospital acquired infections, pressure sores, loss of independence

First 3 months Acute – OPU

- 90% Patients not admitted
- Older adults seen spent less time in A & E
- Reduction in bed usage across Medicine and Older persons wards
Acute-OPU

Acute OPUs
- Aged ≥ 65
- NEWS≤3
- Clinical Frailty scale ≥ 4 (Vulnerable or above)

A & E Majors
A & E Minors

Acute OPU
Consultant Geriatrician specialist assessment supported by Multi-disciplinary team (Physio, OT, specialist nurse, pharmacist, social services)

Home
- Already has F/UP
- OPAU f/up
- With RRT
- With @ home
- Only before 8pm
  - PTWR & OPAL
- Post 8pm
  - PTWR & OPAL
- Other specialist care area e.g SAU
## Home and Frail older persons pathway

<table>
<thead>
<tr>
<th>Admission avoidance</th>
<th>Outpatient DNA Reduction</th>
<th>Shortening hospital admission</th>
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<tbody>
<tr>
<td><strong>Outpatients</strong></td>
<td>Very dependent individuals requiring double handed ambulance crew to get to outpatients/ housebound and no lift</td>
<td>Ongoing medical therapy previously not available at home</td>
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<tr>
<td>- <strong>semi-acute</strong></td>
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<td>- IV antibiotics</td>
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<td>e.g Fast Af</td>
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<td>- IV fluids</td>
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<td>decompensated CCF</td>
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<td>- Short term nebulizer use</td>
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<td>COPD exacerbation needing nebs</td>
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<td>- <strong>medication muddles</strong></td>
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<td>dosette box issues</td>
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<td><strong>LAS Pathway</strong></td>
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<td>- multifactorial falls risk assessment</td>
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<td>and intervention</td>
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<td>- CGA in own home</td>
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<td><strong>Nursing home residents</strong></td>
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<tr>
<td>- Link to advance care plans</td>
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<td>- Delivering healthcare in place of</td>
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<td>residence rather than OPU</td>
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<td><strong>End-of-life care</strong></td>
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<td>- Integrating Geriatrician, @ home and</td>
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<td>palliative care</td>
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<td><strong>Functional support and MDT assessment</strong></td>
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<td>- short term care support</td>
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<td>- Physiotherapy</td>
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<td>- OT</td>
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<td>Multifactorial falls assessments</td>
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@ home next steps/ challenges for frail older persons pathway

• Getting balance right home treatment vs hospital (in and outpatient)

• Continuing to integrate and therefore Reducing duplication
  Hospital/ community/ GP
  Multiple different chronic disease management teams and service Costs

• Strong face validity of evidence based practice for this change to occur

• Local 360 degree @home evaluation under way including patient experience

• National RCT Comprehensive Geriatric Assessment in hospital vs @ home

• Winston Churchill Trust Fellowship- Travel to Australia and New Zealand to review successful evidence based HinH services
GSTT @ HOME Improving Acute Care and discharge planning for older people with frailty

Bringing Care Closer To Home

- GSTT @ HOME is an innovative service providing acute and semi-acute medical care to people in their own homes
- Integrated local NHS ‘acute’ provider
- Without @home a hospital bed would be inevitable
- It is a vital service within the frail older persons’ pathway linking with other innovative parts of this pathway
- It provides older adults an opportunity to avoid hospital admission, stay in hospital for a shorter time and avoid difficult journeys to hospital for outpatient needs
PATIENT COMMENTS

- I was very pleased with the care I got and the kindness to me.
- The only thing I want to say is ... What an amazing service.
- A good and efficient service - Well Done.
- What a lovely and caring people... I would highly recommend this service to anyone. Thank so much for looking after my mum.
- Staff and treatment... excellent, can’t say anymore.