Improving Acute Care and discharge planning for older people with frailty

Guy's and St Thomas @home

Karen Titchener MSc RGN Deputy Head of Nursing

Dr Rebekah Schiff Clinical Lead, Dept Ageing and Health

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Bringing hospital care to your home

Guy's and St Thomas' NHS

NHS Foundation Trust

@home Introduction

- @home is an integrated "Hosptial 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 hosptial 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

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@home 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 Bringing hospital care to your home

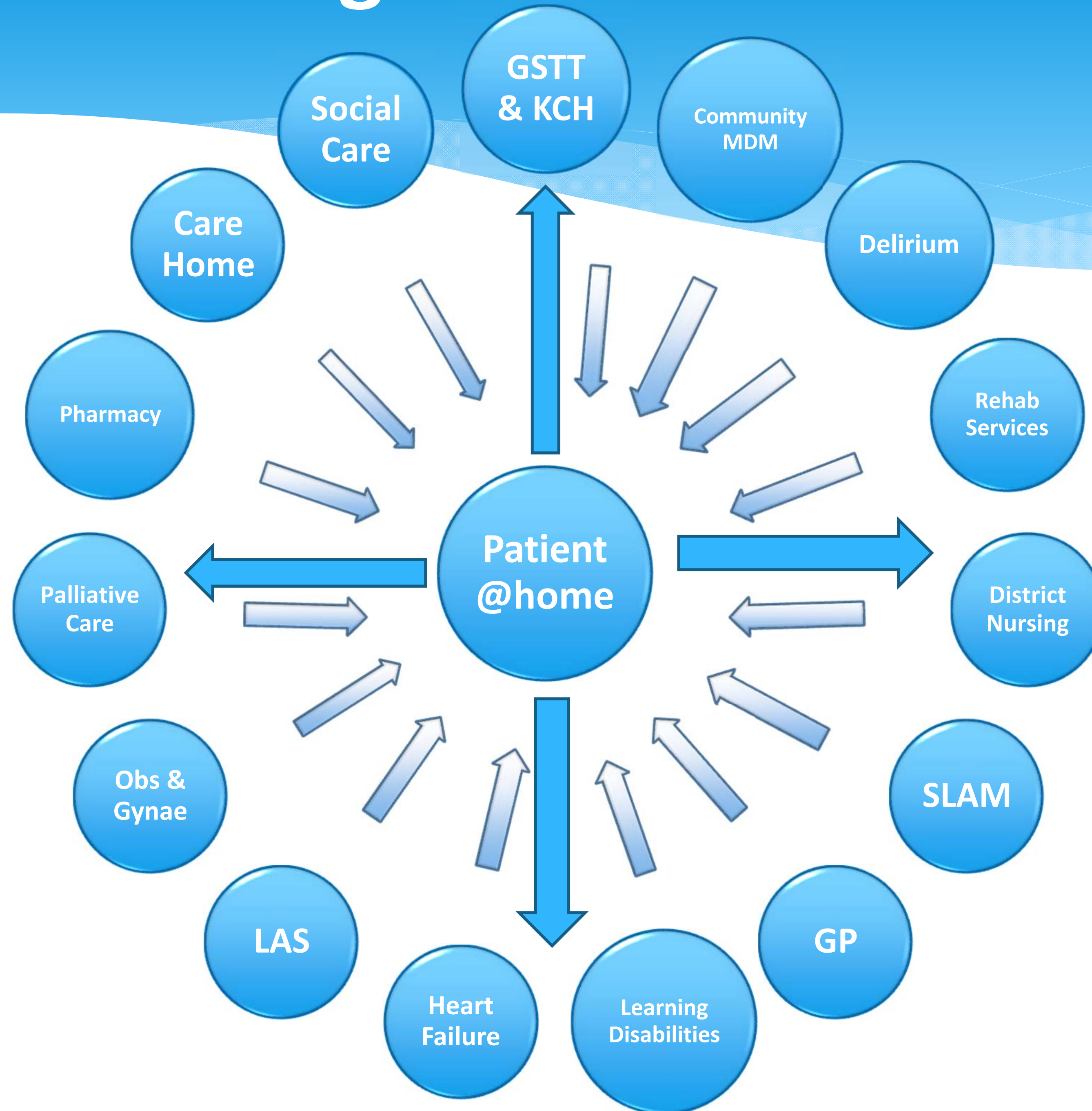
@home look after patents with conditions including

- 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

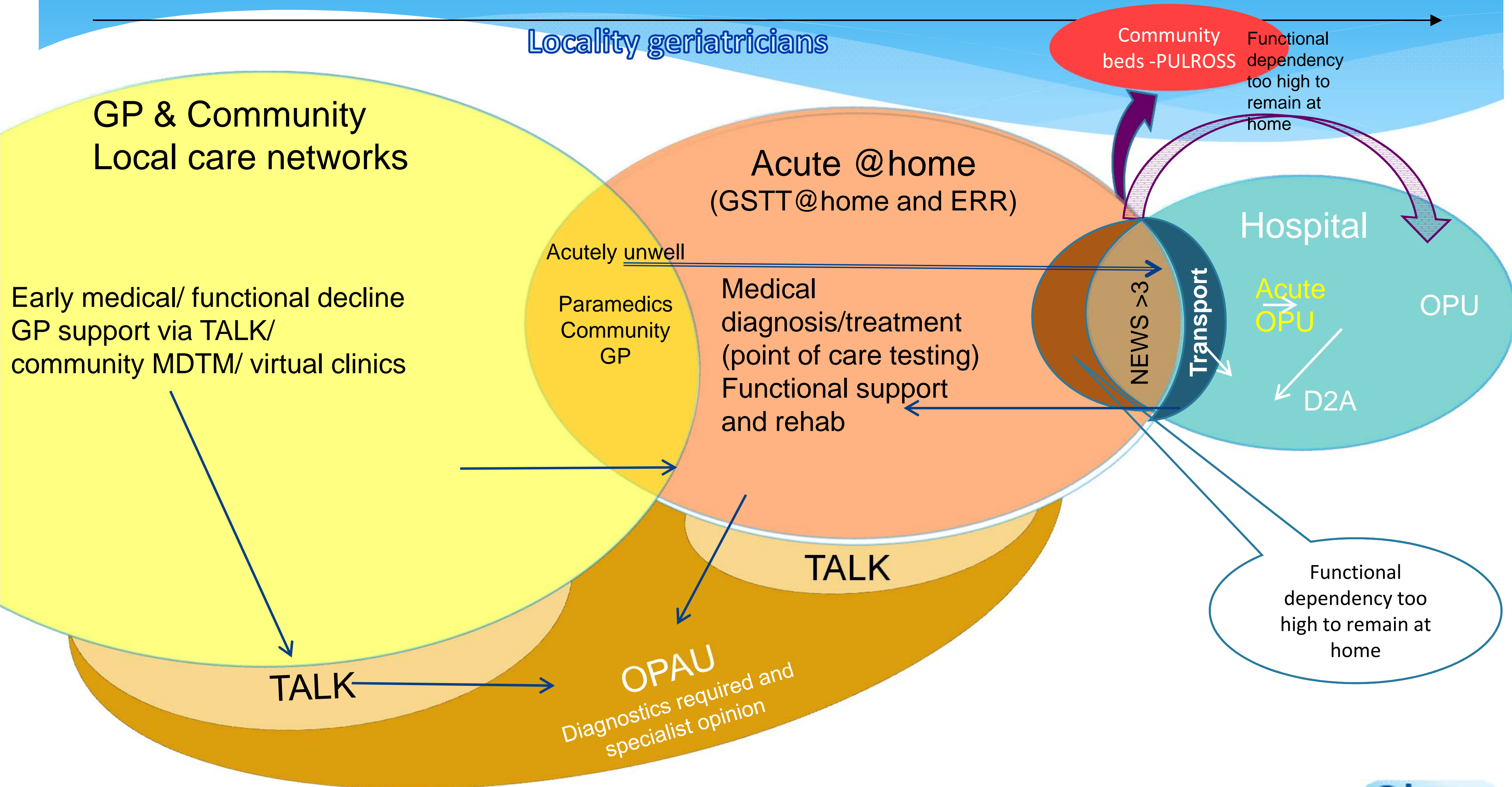
Integrated Partners



@home

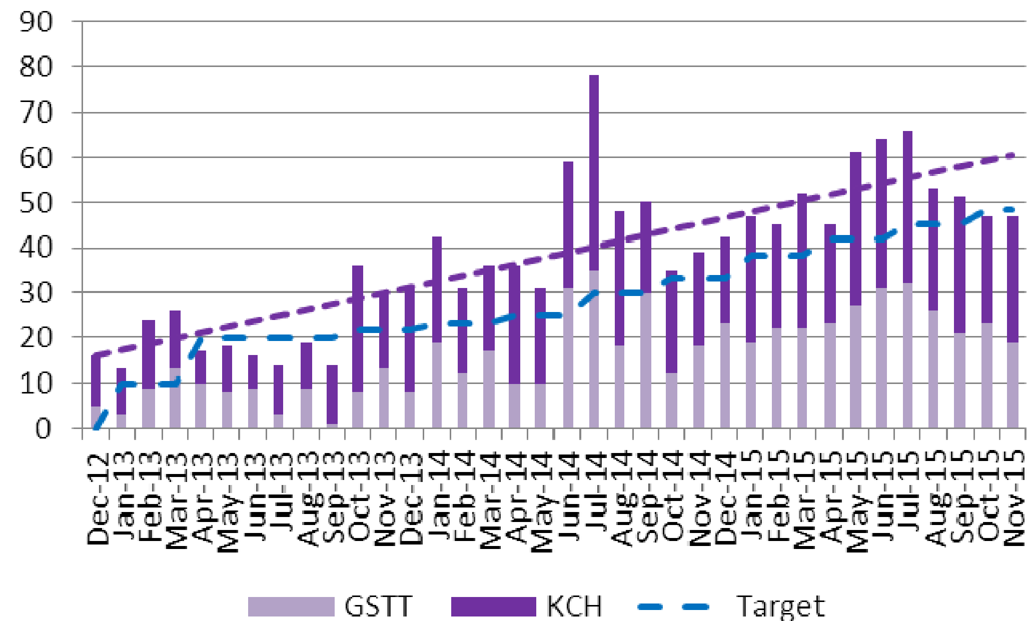
Older persons' pathway

Integrating care across community and hospital at GSTT



TALK

- 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



@home

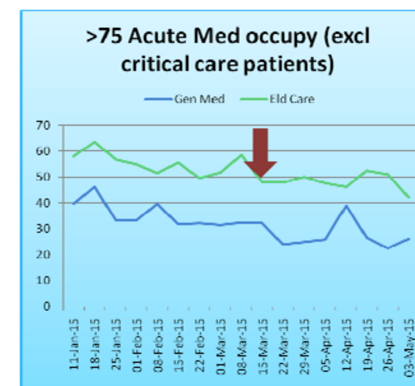
Acute -OPU

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 then 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



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Acute-OPU

LAS

Nurse Triage

A & E Majors

Acute-OPU

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

A & E Minors

Acute-OPU

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

TALK

Home
Already has F/UP

Home
OPAU f/up

Home
With RRT

Home
With @ home

OPU
Only before 8pm
PTWR & OPAL

GIM AAW
Post 8pm
PTWR & OPAL

Other specailast care area e.g SAU

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@ Home and Frail older persons pathway

Admission avoidance	**Outpatient DNA Reduction**	**Shortening hospital admission**
Outpatients - **semi- acute** e.g Fast Af decompensated CCF COPD exacerbation needing nebs - **medication muddles** dosette box issues	Very dependent individuals requiring double handed ambulance crew to get to outpatients/ housebound and no lift - Multi-disciplinary domicillary visit with consultant geriatrician	Ongoing medical therapy previously not available at home - IV antibiotics - IV fluids - Short term nebulizer use
LAS Pathway - multifactorial falls risk assessment and intervention - CGA in own home		Daily monitoring of medical situation - medication uptitration - electrolyte monitoring delirium support
Nursing home residents - Link to advance care plans - Delivering healthcare in place of residence rather than OPU		Functional support and MDT assessment - short term care support - Physiotherapy - OT Multifactorial falls assessments
End-of-life care - Integrating Geriatrician, @ home and palliative care		

@ 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

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

I was very pleased with the care I got and the kindness to me

Staff and treatment… excellent, can't say anymore.

The only thing I want to say is … What an amazing service

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