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Bridging the frailty gap: introducing the inpatient Older Persons' Advice and Liaison Service (OPALS)

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Aims

The introduction of an inpatient Older Persons' Advice and Liaison Service (OPALS) provided comprehensive geriatric assessment (CGA) to frail older patients on outlying wards and proactive step-down to community services, in addition to bridging gaps in knowledge and training.

Methods

Frail older people are frequent users of healthcare services, but often not managed under specialist geriatrician-led multidisciplinary care due to a lack of capacity on geriatric medicine wards. CGA is an evidenced-based intervention associated with reduced length of stay, improved cognitive function and reduced mortality. OPALS was introduced on 12 January 2015, initially supported by winter pressures funding and has continued to be funded as its effectiveness has been demonstrated by outcome data. The team consisted of a middle grade and administrator, working Monday to Friday 8.30am to 5.00pm, supported by a consultant. Process mapping of the pathway for referrals to the geriatric medicine department and step-down to community rehabilitation was undertaken and a new lean pathway introduced. Key features of the new streamlined process were a single point of access for referral from any member of the multidisciplinary team using a standardised form, a centralised database providing visualisation of all frail patients, a waiting list of appropriate patients awaiting step-down to community hospitals, and ensuring that all available beds were used on a daily basis. CGA, including discharge planning, was provided within 24 hours of referral using a standardised assessment tool,and evidenced-based pathways for dementia, delirium, polypharmacy, falls, bone health and continence were used.

Results

250 patients (average age 83) have received standardised, high-quality CGA in the first 6 months, in comparison to 90 patients in the previous 6 months who received variable assessments. The average time from referral to assessment (15 hours) was well within target (24 hours). 194 inappropriate medications were stopped. Weekend discharges to community hospitals increased from 0.3 patients per month to 3.7. Unoccupied bed-days in the community were reduced to 2% per month from 9%. The 30-day readmission rate was 15.7%, compared to 15.4% nationally for patients over 75. The introduction of the pathway and increased utilisation of community hospitals has been estimated to save £360,288 annually.

Conclusions

Quality management systems can be utilised to enhance older people's healthcare through a specialist liaison service delivering CGA. This can align clinical priorities for frail patients in acute hospitals with important business outcomes for trusts. ■

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