Frail Elderly Assessment Unit (FEAU)

Current challenges and future potentials
RCN Older People’s Nursing conference and exhibition

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Elderly care services transferred from community to Acute Trust control in May 2007.

Pathways to Elderly Care wards were non existent with lottery approach to admission from A&E / community / Acute beds within the Trust.

Geriatricians worked across general medical wards as well as designated elderly care wards

Existing elderly care wards seen as long term rehabilitation as opposed to acute elderly care admissions.

Length of stay > 28 days.
Undertaken by Consultant Geriatrician Matron / Therapist

Reviewed patients who were admitted to Emergency Portals and who fitted the Bournemouth Criteria to ensure appropriate admissions to Elderly Care beds

Daily basis – saw approximately 5 – 8 patients in total

A high proportion of patients who were identified for Elderly Care from this service eventually outlay within the Trust with no further Geriatrician input.

Length of stay for outliers longer than average expected.

Multi-disciplinary ‘Safari ward rounds’
Original Frail Elderly Care Model (pre April 09)

A&E → MRA → Inter site transfer

MRA:
- Identified as Frail Elderly utilising the Bournemouth Criteria
- Ward 85 female
- Ward 86 male
- Ward 65 Female / general med

Inter site transfer:
- Any medical ward

Discharge:
- Community Hospital Nursing/Residential Home/Normal place of residence etc
- Delayed discharges-Ward 62

Any available bed onward 85 / 86 for step down – delayed discharge on going care.
Early Transformation of Service April 2009 - 2010

- Ward 21B developed (pre FEAU)
  - 11 bed acute admissions unit for those patients attending A&E / Emergency portals who fitted Bournemouth Criteria
  - Cohorted Elderly Care and negated need for ‘safari ward rounds’ so efficiency made in terms of time
  - Dedicated Elderly Care nursing Staff
  - Supported by 2 ANP’s / but no consistent medical cover
  - Morning Consultant ward round daily
  - Relied on A&E / MRA identification of suitable patients
  - Patients transferred from 21B to Elderly Care Wards – acute admission and step down
Positive outcomes

* Increased numbers of frail older people cared for in Elderly Care Unit (right patient right place)
* Fewer FE outliers
* Dedicated Elderly Care Unit with care delivered by appropriate staff with skills and competencies associated with speciality

Negative Outcomes

* Not always identified early in A&E therefore access to the FE Unit inconsistent
* Too many patient moves increased incidence of infection
* Little effect on average LOS which remained > 28 days (GS 12)
* Infrequent therapist cover
* Infrequent cover from specialist teams
* Little medical cover after Geriatrician ward round
* Beds not trolleys (became a ward quickly with a 3 week LOS)
Transformation team review and progression: January 2010

* Reviewed evaluations and work on-going within the LHE to support admission avoidance.
* Agreed early access to Consultant Geriatricians key to provision of appropriate care for frail population – needed to be extended
* MDT approach was vital to ensure that all aspects of care reviewed and managed / implemented proactively to avoid unnecessary acute admission
  * Therapies OT / PT
  * Medical Cover
  * Social Workers / ‘PULL TEAM’
  * Specialist Nurses- Palliative care / TVN
  * Voluntary services (Brighter Futures)
* 24 hour medical cover – 7 days a week
* Proactive ‘pull’ of patients from emergency portals
* Direct access from the community
FEAU (The Frail Elderly Assessment Unit)
What does it look like now?
Opened October 2010 – moved to new Unit March 2011

* 14 available spaces with 14 Stryker trolleys
* Consultant Geriatrician cover 9 – 8 weekdays and 9 – 3 weekends
* Always B6 above on duty + B5’s and 2’s
* MDT approach from all services health / social care/ pharmacy
* Dedicated therapists
* Priority given for all investigations
* Clear exclusion / Inclusion criteria
* Dedicated telephone lines
* Hospital Information System tracker – with < 24 hour target linked to all other emergency portals
How it works

* Referrals from:
  * Community (including Ambulance service and GP’s)
  * Emergency portals
* B6 co-ordinator screens patients against telephone information log.
* Decision to admit is based on BC and acute Inclusion or exclusion criteria.
* If patient is to be admitted to FEAU, will attend and be placed on a trolley / bed as pre requirement
* Initial baseline assessment undertaken by nursing staff and patient triaged according to clinical condition (within 15 minutes or sooner dependent upon condition)
* Patient reviewed and clerked by medical team in order of priority’ Usually with 15mins of arrival
* Timely decision to admit / discharge <24hour target
* Decision to admit? patient transferred to next available EC bed
* Decision to discharge? referrals will be made where necessary to support those patients who are going back to their original place of residence
* Dedicated team of community health and social care colleagues, enables this to happen
**FRAIL ELDERLY ASSESSMENT UNIT TELEPHONE REFERRAL LOG SHEET**

Before completing this form firstly check with the Referrer to see if there is potential for this patient to receive a rapid ambulatory assessment and treatment and be returned to the community. If YES refer to UCC.

<table>
<thead>
<tr>
<th>Enquiry/Referral Details</th>
<th>Date: <em><strong>/</strong></em></th>
<th>Time: <em><strong>/</strong></em> am/pm</th>
</tr>
</thead>
<tbody>
<tr>
<td>Source of Enquiry/Referral (circle one)</td>
<td>Urgent Care Centre / A&amp;E / SPC / UHNS Ward / Other (please state)</td>
<td></td>
</tr>
<tr>
<td>Name of Referring Clinician</td>
<td>Contact Telephone Number</td>
<td></td>
</tr>
</tbody>
</table>

**Patient Details**

- **Surname**: 
- **First Name**: 
- **Age**: 
- **Date of Birth**: 
- **NHS Number**: 
- **Address**: 
- **GP Name/Address**: 

**Patient History**

- **Meets Bournemouth Criteria? (see opposite)** YES NO
- **Presenting Complaint with Relevant PMH**: 

**VITAL SIGNS**

- **Temp**: 
- **Pulse**: 
- **O₂ Sat’s on air**: 
- **B/P**: 
- **Resps**: 
- **GCS**: 
- **BM**: Name and designation of person providing this information

**FEAU EXCLUSION CRITERIA**

<table>
<thead>
<tr>
<th>SUSPECTED NEW CVA OR TIA</th>
<th>YES</th>
<th>NO</th>
</tr>
</thead>
<tbody>
<tr>
<td>TRAUMA WITH SUSPECTED FRACTURE</td>
<td>YES</td>
<td>NO</td>
</tr>
<tr>
<td>HEAD INJURY WITH LOSS OF CONSCIOUSNESS</td>
<td>YES</td>
<td>NO</td>
</tr>
<tr>
<td>ACUTE ABDOMINAL PAIN WITH COLLAPSE</td>
<td>YES</td>
<td>NO</td>
</tr>
<tr>
<td>ACUTE COLLAPSE GCS &lt; 9</td>
<td>YES</td>
<td>NO</td>
</tr>
<tr>
<td>RESUSCITATION IN PROGRESS</td>
<td>YES</td>
<td>NO</td>
</tr>
<tr>
<td>ADMISSION SOLELY FOR RENAL DIALYSIS</td>
<td>YES</td>
<td>NO</td>
</tr>
<tr>
<td>CHEST PAIN WITH SUSPECTED MI</td>
<td>YES</td>
<td>NO</td>
</tr>
</tbody>
</table>

**Answer YES to any of the above – these patients must be directed to the Emergency Department**

**FEAU INCLUSION CRITERIA**

| PATIENT HAS EXPERIENCED AN ACUTE ADMISSION OF ≥7 DAYS WITHIN THE LAST 6 MONTHS | YES | NO |
| SUSPECTED UTI WITH PYREXIA | YES | NO |
| PNEUMONIA / EXACERBATION OF COPD | YES | NO |
| ACUTE / INCREASING CONFUSIONAL STATE | YES | NO |
| DEHYDRATION / NAUSEA / VOMITING | YES | NO |
| INCREASING FALLS, WITH BALANCE DEFICIENCY | YES | NO |
| SHORTNESS OF BREATH | YES | NO |
| NON SPECIFIC PLEUROTIC CHEST PAIN | YES | NO |
| CHRONIC ABDOMINAL PAIN – NOT ACUTE ONSET | YES | NO |

Failure to Cope at Home and/or Breakdown of Care Package without acute medical problem should not require admission to FEAU – Please consider referral to:

- Single Point of Contact
- Community Matron
- Rapid Access Clinic Appointment

Referral Made: Y/N (Please delete and give details overleaf)
Bournemouth Criteria

- 90 years or above
- 65 years from a nursing or residential home or community hospital
- 75 years from home with 2 or more pre-existing conditions

1. Acute confusion
2. History of falls
3. Incontinence of urine and/or faeces
4. Reduced mobility
5. Dementia (AMT less than 7)
6. Care package breakdown
7. Multiple pathology
Inclusion Criteria

* Patient has experienced an acute admission of >7 days within the last 6 months
* Suspected UTI with pyrexia
* Pneumonia / Exacerbation of COPD
* Acute/ increasing confusion
* Dehydration / nausea / vomiting
* Increasing falls with balance deficiency
* Shortness of breath
* Non specific chest pain
Exclusion Criteria

* Suspected or new CVA/TIA
* Acute chest pain/suspected MI
* Trauma with a suspected fracture
* NOF’s
* Head injury/trauma, unconscious GCS <9
* Collapsed patient requiring resuscitation
* Acute abdominal pain with collapse
* Unstable Blood glucose <3 or > 28

These patients will be diverted to A&E /HAC/ SAU
On-going review and monitoring systems

- Monthly review meetings re; admissions and discharges / length of stay and issues of concern
- Monthly commissioner / PCT based reviews to ensure timely discharge and support from community to support admission avoidance work.
- Internal data review to ensure those patients who were declined admission were appropriately managed elsewhere (telephone log)
- Development of SOP’s to support operational smooth running of unit and review of these / TVN
- Development of nurse-led outreach service with ANP’s and Unit Manager in development phase.
- Documentation reviews
- Adverse incident reviews monthly
- Regular review meetings with key A&E staff
Thank you for listening

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