Specialist Physiotherapist (SPT) Leading in the Frailty Revolution in Ambulatory Emergency Care at The John Radcliffe Hospital, Oxford

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BACKGROUND

The Ambulatory Assessment Unit (AAU) at the John Radcliffe Hospital aims to provide excellent care for complex patients with a varying range of medical presentations. During operational hours, AAU sees 50% of the acute medical take. This represents 30% of the hospital’s acute medical take in a 24 hour period. Of those seen by AAU, 40% are over the age of 70.

Staff feedback consistently identified a suboptimal service provided to patients attending the unit with frailty. A specialist physiotherapist (SPT) joined the team in October 2018 to address this.

SPT ROLE AIMS

1. Ensure early identification of patients with frailty attending the ambulatory unit;
2. Improve staff understanding of frailty to enhance care;
3. Assess patients to either enable a patient to return home safely or support a patient’s ambulatory pathway;
4. Refer to community services that can support the patient and enable them to live well after their hospital attendance;
5. Review the impact of the SPT role.

SPT METHODS

1. Introduction of frailty identification as per frailty team guidance;
2. Frailty questionnaire to ascertain baseline understanding and learning needs to develop staff training;
3. Use an adapted CGA for therapy assessments;
4. Raise staff and patient awareness of community support services available within the community;
5. Data collection to review interventions taken, bed days saved and re-attendance rates.

RESULTS: IN A FOUR MONTH PERIOD

- 77 Patients Referred
- 65 Patients signposted to community & support services
- 29 Patients to other Services
- 32 Patients to Community Therapy Services
- 16 Patients to Community Nursing Teams
- 129 Patients seen by SPT
- 64% Ambulatory pathway supported
- 21% Acute admission avoided directly due to therapy
- 85% Returned home the same day
- 30 bed days saved
- 15% Admitted to an acute bed for safety

Re-admission Rates for Therapy Related Reasons

- Admission Avoidance
  - Average Rockwood score = 6.31
  - 7 days = 0%
  - 30 days = 10%

Ambulatory Pathway
- Average Rockwood score = 5.16
- 7 days = 0%
- 30 days = 2.6%

PATIENT PRESENTATION: DAY 0

HPC: SP referral for reduced urine output, lethargy, cachexia and increase oedema despite furosemide.
PMH: Ca breast, colorectal Ca (both in remission), AF, heart failure, IM, HTN, osteoporosis, hypothyroidism.
SH: Lived alone in a warden controlled flat. Patient independent with PADOs and had good family support for DADLs. Mobilised 15m with a WGT.
Diagnosis: Decompensated cardiac failure, PMR, UTI, VTE, ?malignancy. Referred to breast cancer and metabolic bone clinic appointments.
Patient ambulated and received medical treatment at home by Acute Hospital At Home. Returned to AAU on day 8.

SPT ASSESSMENT

SPT Assessment Day 8: Completed adapted CGA. Shortness of breath on exertion and pain impacting on patient’s function and independence. SPT enabled patient to identify her wishes and goals:

- Return home and continue to live in her own home for as long as possible;
- For someone to help her with morning personal care.

Patient’s wishes:
- To manage bed transfers more easily;
- To maintain functional independence;
- To have a continence management plan;
- Discuss advanced care planning.

SPT INTERVENTION

SPT referred to the Integrated Locality Team (ILT) for community nursing and therapy intervention. Family provided with Live Well Oxfordshire booklet. Advice to family about arranging care package with on-site carers at the flat.

Day 11: Seen at home by ILT nurse who discussed advanced care planning; patient decided that she did not want further treatment her heart failure or investigations for potential malignancy.

Day 14: Seen by community OT, function and equipment needs assessed. Care package started the following day to assist with morning personal care.

OUTCOMES

Day 15: AAU follow up and decision made for symptom palliation only. Referred to palliative care. Clinic appointments cancelled.

Day 16: Initial assessment by community palliative care team. Patient’s needs and wishes supported by them until day 51.

Day 51: Patient died at home.

SPT intervention enabled the patient to access community services that could support her to meet her needs and fulfil her wishes after attending hospital.

CONCLUSIONS

- The resulting cost saving is £15,162 in a four month period.
- A dedicated therapy service in an ambulatory setting has a role in ensuring that patients needs are met in the most appropriate place and enhances their quality of life after hospital attendance.

CASE STUDY: 87 YEAR OLD FEMALE, CLINICAL FRAILTY SCORE 5

FUTURE SERVICE DEVELOPMENT

- There is ongoing work to obtain further patient experience data for those who had their admission avoided directly with therapy intervention.
- A training programme for staff on frailty is to be developed.

"Ambulatory Pathway”